V. 91 no. 1

WMJ

Wisconsin Medical Journal

January 1992

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Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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Contents

January 1992 Vol. 91 No. 1

Opinions

3 *President's page*
150 years of SMS; enter Medicare RBRVS
'Medicina nusquam non est' (medicine is universal): VIII
by Cyril M. "Kim" Hetsko, MD, Madison

5 *Secretary's report*
150 years of caring for Wisconsin
by Thomas L. Adams, CAE

7 *Soundings*
Sample cover letter for journal manuscript resubmissions
Reprinted from *Dialogue*

8 *Letters*
WIPRO called an "evil system"
by James P. Fogarty, MD, Barron

Special

9 The RBRVS: a primer
by the SMS Division of Medical Policy and Practice

10 RBRVS primer table of contents

Socioeconomic

43 *Public health*
Project FACE: Wisconsin surveillance of fatal occupational injuries
by Lawrence P. Hanrahan, MS; Dee Higgins, RN; Linda Haskins; and Henry Anderson, MD, Madison

Organizational

47 Bushnell B. Cary, MD: The first president of the State Medical Society of Wisconsin
by Earl R. Thayer and Thomas J. Wolfe, Madison

49 A glimpse into our past
by Richard D. Sautter, MD, medical editor

50 County society news

52 Obituaries

Our cover: The nuts and bolts of RBRVS implementation can be found in this issue's special section, starting on page 9. Cover art by Comstock Photo.

President's page

150 years of SMS; enter Medicare RBRVS

'Medicina nusquam non est' (medicine is universal): VIII

THIS YEAR WE CELEBRATE the 150th year of the founding of our organization, and the SMS will be taking special note of our sesquicentennial during the coming months. The SMS was chartered by the Wisconsin Territorial Legislature in 1841 and held its first meeting in 1842.

Many changes have occurred over the last 150 years, and January 1992 will be no different–with the implementation of the federal RBRVS for Medicare along with the Medicare use of totally new codes for evaluation and management services.

This month may be somewhat confusing as all practicing physicians will have to start using these new systems. This issue of the *WMJ* contains a self-help and referral RBRVS guide to assist us in this transition.

The evolution of the RBRVS can be traced at least as far back as 1983, when the federal government "solved" the problem of rising hospital costs for Medicare by instituting the DRG payment system. The eyes of the policy makers then turned hungrily toward physicians, and it was clear in Congress and in the White House that the "customary, prevailing, and reasonable" (CPR or UCR) physician payment system was about to pass into extinction.

Sen Bob Dole declared open season on doctors when he declared 1984 the "year of the physician." Both Congress and the Reagan administration blamed the CPR or UCR system for the growth in Medicare payments to physicians, and both looked for alternatives. The Reagan White House made a series of legislative and administrative proposals to eliminate fee-for-service in favor of physician DRGs, mandatory capitation and mandatory assignment.

Meanwhile, widespread dissatisfaction among physicians with the inequities and distortions of Medicare payments across specialties and geographic regions and with the increasing complexity of the CPR or UCR led to the proposal of a reform known as the relative value scale–the embryo of the RBRVS. The idea was to create a rational, scientifically based alternative to a Congressionally created fee schedule, which–if experience with early Medicare is an indicator–would have been based as much on politics as anything else.

I must emphasize here that *no* change was not an option. If physicians did not participate in creating a reform package, Congress was prepared to implement its own arbitrary physician payment schedule.

The bulk of the work on RBRVS was completed by 1988, and the legislation was passed in late 1989 (OBRA '89) to implement it over 5 years starting in 1992. The bill reflected compromises by Congress, the Bush administration, patients, and physicians.

Cyril M. "Kim" Hetsko, MD

As you know, the Bush administration in 1991 proposed a 16% cut in the RBRVS reimbursement as originally passed in 1989. All too often, state and federal governments have reneged on the promises they make. It was with the grassroots support–shown in 100,000 letters from across the country–and the efforts of many individual physicians, the SMS, the AMA and specialty societies that a good part of these cuts were restored.

It is important to remember that the job is not done; the evolution of the RBRVS is not complete, and physician in-

Continued on next page

Continued from preceding page
volvement will continue to be imperative. For example, at its December meeting, the AMA adopted a number of resolutions with the intent of improving RBRVS. One such resolution calls for the AMA to "take the position that the RBRVS-based Medicare physicians payment schedule requires substantial improvements in many of its key elements and that the AMA cannot endorse this new system until substantial improvements are made."

All things considered, however, the new system is an improvement over the old. As it passes through its stages of implementation between now and 1996, the RBRVS should increasingly prove to be simpler and more uniform than the CPR or UCR. It should also provide needed relief for physicians and their patients in rural areas and primary care practices.

The danger of the RBRVS is its potential for divisiveness. As frustrated–even angry–as we may become in adjusting to the new system, we must be wary that we do not turn physician against physician. As has been demonstrated over this long and arduous process of developing the RBRVS, our unity remains our strength. Organized medicine has played a key role from the inception, and will continue to fulfill its obligations to member physicians.

. . .the evolution of the RBRVS is not complete. . .

As we look to the future, we must seek further improvements to assure the availability of services for our senior citizens. At its December meeting, the AMA pledged to "assign a continued high priority to legislative correction of grossly inequitable elements of Medicare physician payment policy as the lack of any payment for interpretation of EKGs, discriminatory payment reductions for 'new' physicians, unfounded payment limits for the services of assistants-at-surgery, definition of new patients, and the discriminatory 50% co-payment imposed on mental illness."

Additionally, the AMA will seek "a second Medicare participation decision period between June 1 and July 1, 1992, to allow physicians to reconsider the decision that they were forced to make in December 1991 on the basis of often limited information."

The new RBRVS system is here. The new evaluation and management codes are to be used. The SMS will keep you abreast of changes and will continue to work with the AMA and specialty societies on needed improvements to the government RBRVS program.

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Secretary's report
150 years of caring for Wisconsin

The views of all those progenitors of medical science who have gone before us will ever live on and on, and today they present themselves to us like the waves on the ocean of truth. They have acted on our minds and left more or less permanent marks, like those of the receding tides upon the sands, marks of nomenclature which the succeeding medical geologists will have to decipher. For, after all, truth ever old is ever new. What is today, is the result of what has been in past ages; and the same forces are at work evolving the future. And as a consequence the advances in our knowledge in medical science with the last quarter of a century are without a parallel in any age. Never was the medical profession so busy and industrious, so zealous and enthusiastic, so honest and exact in its views and its results, as at the present moment.

Look where we may, progress, rapid and brilliant, nay in some respects absolutely bewildering, literally stares us in the face and challenges our respect and admiration.... And yet it would ill become us to be unmindful of the fact that much of this knowledge, so much boasted of, is an inheritance, a reflection of the past, a legacy transmitted from sire to son, an accumulation of the industry, the genius, and the wisdom of other days crowned with glory, and sometimes even with martyrdom.

Thomas L. Adams, CAE

I KNEW WHEN I FIRST READ the above passage that it would serve as a fitting toast to the 150th anniversary of the State Medical Society of Wisconsin. Truer words are seldom spoken about the state of modern medicine, its debt to the past, and its promise for the future. So it is with some amazement that I attribute the quote to the president of the SMS of 1892, F.G. Witter, MD. Then again, perhaps it's not so amazing after all.

Given the common characteristics of the diverse people who make the science and art of medicine their life's pursuit–intellect, curiosity, compassion, and commitment–it is not surprising that each successive moment in the history of medicine is its finest. As we honor your profession's 150 years of caring for Wisconsin, however, it would truly "ill become us" to overlook that today's triumphs are built on yesterday's conquests and serve as only the foundation for tomorrow's glories.

Beginning with this issue and continuing throughout the year, the *WMJ* is going to celebrate your Society's 150 years of accomplishments. Medicine being an activity of, for, and by people, the focus of the *WMJ*'s efforts will be on the people of historic importance or interest in the development of medicine in Wisconsin. On page 47, you'll find the first installment, the fascinating story the first SMS president and the correction of century-old error, written by my predecessor, Earl Thayer.

Reviewing the records of the Society is an amazing lesson in history, both generally and in specific regard to the SMS. Wisconsin's early physicians wasted little time in using their new association to enhance the public health. In 1948, the Society called for the inspection of all drugs and medical preparations by chemists and the destruction of any found to be impure. The following year, the Society emphasized the importance of medical education and the danger of medical quackery by requiring candidates for membership to pass an examination. A year later, in 1850, the Society began negotiating for the establishment of a medical school at the University of Wisconsin and lobbying for a bill to require the gathering of vital statistics. In 1851, the Society began studying ways of protecting the public from "quacks, quackery, patent medicines and nostrums;" lobbied for the right of medical students and doctors to dissect human bodies for study; and called for the English labeling of all medicines.

Continued on next page

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

Editorials are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of editorials is reserved for members of the *WMJ* editorial board, editorial associates and SMS elected officials.

Letters are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of letters is open to the public, but letters are limited to 500 words and subject to review by the *WMJ* editorial board. Write to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.150th

Continued from preceding page
And so it went, and so it goes.

The SMS has a long history of fighting for the public health, directly and indirectly. An important indirect protection of public health has been the effort to raise both the quality of care provided and the standards of ability and character for physicians. For instance, in 1897, after 28 years of lobbying, the SMS won passage of a bill to establish the early Medical Examining Board, and in 1925 the SMS won passage of the nation's first basic science law, which required anyone professing to treat the sick to "possess a basic knowledge in the subjects of anatomy, pathology, diagnosis and physiology." Of course, your current efforts to further enhance medical education, continuing education, scientific publication, public health education and professional ethics are proper additions to that proud chronology.

Interestingly, some of the issues facing medicine today have been encountered before. In 1938, the call for what was then known as "socialized" medicine prompted the Society to send Secretary George Crownhart abroad for several months to study the "sickness insurance in Europe." The secretary's report on his travels and first-hand study were published in book form and played an important part in the discussions of that time. Again, your current efforts, as individuals and as members of the Society, to increase access to care and serve the uninsured population are indispensable elements of the modern debate.

You deserve to take great pride in your Society, for by joining forces your predecessors were able to weather seven score and 10 years of political battles, wars, charlatans, and devastating epidemics, all the while pushing the profession and the public health toward ever greater heights. The history of medicine in Wisconsin has been a history of "progress, rapid and brilliant, nay in some respects absolutely bewildering." It is a history that you and your peers are now continuing; a history that your successors and theirs will gratefully acknowledge and then build on.

Perhaps the most peculiar–and most profound–aspect of looking back is that doing so compels you to look forward. Indeed, the opportunities, the possibilities, the future of a profession with such a past is nothing short of breathtaking.[150th]

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Soundings

Sample cover letter for journal manuscript resubmissions

Roy F. Baumeister

Dear Sir, Madame, or Other:

Enclosed is our latest version of Ms #85-02-22-RRRRR, that is, the re-re-re-revised revision of our paper. Choke on it. We have again rewritten the entire manuscript from start to finish. We even changed the goddam running head! Hopefully we have suffered enough by now to satisfy even you and your bloodthirsty reviewers.

I shall skip the usual point-by-point description of every single change we made in response to the critiques. After all, it is fairly clear that your reviewers are less interested in details of scientific procedure than in working out their personality problems and sexual frustrations by seeking some kind of demented glee in the sadistic and arbitrary exercise of tyrannical power over hapless authors like ourselves who happen to fall into their clutches. We do understand that, in view of the misanthropic psychopaths you have on your editorial board, you need to keep sending them papers, for if they weren't reviewing manuscripts they'd probably be out mugging old ladies or clubbing baby seals to death. Still, from this batch of reviewers, C was clearly the most hostile, and we request that you not ask him or her to review this revision. Indeed, we have mailed letter bombs to four or five people we suspected of being reviewer C, so if you send the manuscript back to them the review process could be unduly delayed.

Some of the reviewers' comments we couldn't do anything about. For example, if (as reviewer C suggested) several of my recent ancestors were indeed drawn from other species, it is too late to change that. Other suggestions were implemented, however, and the paper has improved and benefitted. Thus, you suggested that we shorten the manuscript by 5 pages, and we were able to accomplish this very effectively by altering the margins and printing the paper in a different font with a smaller typeface. We agree with you that the paper is much better this way.

One perplexing problem was dealing with suggestions #13-28 by Reviewer B. As you may recall (that is, if you even

Continued on next page

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Continued from preceding page
bother reading the reviews before doing your decision letter), that reviewer listed 16 works that he/she felt we should cite in this paper. These were on a variety of different topics, none of which had any relevance to our work that we could see. Indeed, one was an essay on the Spanish-American War from a high school literary magazine. The only common thread was that all 16 were by the same author, presumably someone whom Reviewer B greatly admires and feels should be more widely cited. To handle this, we have modified the introduction and added, after the review of relevant literature, a subsection entitled "Review of Irrelevant Literature" that discusses these articles and also duly addresses some of the more asinine suggestions in the other reviews.

We hope that you will be pleased with this revision and will finally recognize how urgently deserving of publication this work is. If not, then you are an unscrupulous, depraved monster with no shred of human decency. You ought to be in a cage. May whatever heritage you come from be the butt of the next round of ethnic jokes. If you do accept it, however, we wish to thank you for your patience and wisdom throughout this process and to express our appreciation of your scholarly insights. To repay you, we would be happy to review some manuscripts for you; please send us the next manuscript that any of these reviewers submits to your journal.

Assuming you accept this paper, we would also like to add a footnote acknowledging your help with this manuscript and to point out that we liked the paper much better the way we originally wrote it but you held the editorial shotgun to our heads and forced us to chop, reshuffle, restate, hedge, expand, shorten, and in general convert a meaty paper into stir-fried vegetables. We couldn't, or wouldn't, have done it without your input.

Sincerely,

–submitted by Richard D. Sutter, MD
medical editor

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Letters

WIPRO called an 'evil system'

To the editor: One's political persuasion should not enter into a peer review system, but I feel that such an event is happening.

Since my letter to the *Wisconsin Medical Journal* concerning the tyrannical approach of the system of WIPRO, I have been reviewed and received penalty points for frivolous action. Fighting these reviewers takes a great deal of time, effort, and a commitment to the basic belief that peer review cannot occur in a situation in which the reviewer is being paid to find fault. The reviewer is being used to contain costs and the reviewer is given leeway as to individual judgement decisions without those being reviewed having the same privilege.

In discussing specific arguments with reviewers, I have found a common philosophy and that is: Outcome is not an indicator of quality of medicine. I have even had so much as an individual telling me they would fight me to the death in regard to outcome being any indicator of quality of medicine.

I think we need to reflect what quality control of medicine involves–that is the patient. The final analysis of quality of care to the patient is whether things turned out right. If we loose sight of this and start getting bogged down by judgement decisions, mild discrepancy in lab data, etc, we cannot begin to justify our existence as physicians.

Understanding the principles of such an evil system as WIPRO is not difficult. Understanding active participation by individuals who have a common sense approach to quality of medicine is difficult.

I will continue to defend my right as a practicing physician to use what I consider good judgement and documentation in the care of my patients. I only hope that as the tentacles of WIPRO continue to expand and engulf our very freedom of practice that we rise up and challenge the very existence of such a evil system.

–James P. Fogarty, MD
Barron

The RBRVS: a primer

SMS Division of Medical Policy and Practice

CHANGE IS TRAUMATIC. Whether it's good, bad or some of both is irrelevant. For physicians, the Resource Based Relative Value Scale (RBRVS) brings significant change. For some, the revaluing of physician services is mostly good. For others, it portends significant reductions in Medicare income. For all, it is traumatic. What has come to be called "the transition to RBRVS" is not simply the adoption of a new fee schedule. It also affects the way medicine is practiced. From the new system for coding of visits to the new surgery and EKG policies, what most physicians will be feeling is the ordeal of change. They will also be experiencing the trauma of the unknown. Hundreds of specific questions remain unanswered and working through them will take time.

The SMS has devoted this issue of the *WMJ* to supporting physicians and their office staff with information that it hopes will ease the transition. To make the use of this information as easy as possible, the section begins with a directory of the topics covered and the relevant pages. Immediately following, is a list of questions we have been receiving most frequently, with reference to the page on which you can find the answer. There is also a resource directory that refers you to sources for more information and for additional help in solving a particular problem.

The SMS recognizes that you will have many unanswered questions. Please keep asking them. The SMS staff is seeking the answers through regular meetings with WPS-Medicare and through AMA channels. Over the months to come, the SMS will continue to provide you with as much information as possible through publications including *Medicare Alert, Medigram,* and the *WMJ.*

How to use this primer

- Refer to page 10 for an in-depth listing of topics and where to find them.
- Refer to page 11 for a listing of the most common questions and where to find the answers.
- Refer to the resource directory on page 14 to find out where you can get more information and additional help.

We need you.

American Heart Association

Support research.

American Heart Association

RBRVS primer table of contents

11 The most commonly asked questions, and where to find answers

14 Resource directory
- Topics covered:
- The SMS: How and whom to contact
- WPS-Medicare: How and whom to contact
- How to order:
  - Medicare Part B Reference Manual
  - Laminated grids for new CPT-4 codes
  - CPT-4, ICD-9 and HCPCS level II code books
  - UPIN directories
  - *Federal Register* with RBRVS final rule, and AHPB
- Upcoming Medicare and coding seminars
- Medicare reform videos developed by the Marshfield Clinic, SMS, WPS-Medicare and WMGMA

18 The history and future of the RBRVS, in brief

22 Physician fees under the RBRVS
- Methodology
- Relative value units
- Geographic adjustment
- The 1992-1996 transition to the RBRVS

22 Understanding the Medicare fee schedule disclosure
- Established physicians
- New physicians
- How fees are derived

25 Calculating fees for 1992
- Wisconsin Medicare localities

29 The new CPT-4 codes
- Why a change is needed
- How to use the new codes
- Grids for outpatient, inpatient and consultation services
- When to begin using the new codes
- Other changes influencing the codes
  - New and established patient definitions
  - Critical care
  - New modifier for prolonged evaluation and management
- CPT-4 book format changes

34 Other policies effective January 1
- Major surgery
- Minor surgery and non-incisional procedures
- New modifiers
- Multiple surgery
- Bilateral surgery
- Less than global service
- Assistants-at-surgery
- Co-surgeons and surgical teams

39 Payments change for interpretation of EKGs

39 UPINs required Jan 1

39 Type of service codes no longer required

40 Place of service code changes

41 Payment for supplies detailed

41 CMN forms require physician completion

41 New HCFA 1500 claim form instructions

42 Budget cuts affect Medicare claims review

42 Extra care required on ICD-9 codes

The most commonly asked questions, and where to find answers

Fee schedule

1. How do I read my fee schedule?
   Page 22-24
2. What can I do if I don't agree with the fee schedule amount?
   Page 24
3. What do I do if I did not receive a fee schedule or need another copy?
   Page 24
4. If I need a limiting charge for a service that is not listed on my fee schedule, what do I do?
   Page 23

New physicians

1. What is Medicare's definition of a new physician?
   Page 23
2. I am in my first year of practice. How will my Medicare payments be affected now and in the coming years?
   Page 23-24
3. Does my fee schedule reflect the new physician cut back or do I have to calculate the cutback myself? What about my limiting charge?
   Page 24
4. When does my first year of practice begin according to Medicare?
   Page 23

CPT code changes

1. Is there a crosswalk available between the 1991 CPT codes and the 1992 CPT codes?
   Page 30
2. When are the new codes effective?
   Page 32
3. How will I code visits provided in 1991 if the claim is not submitted until after Jan 1, 1992?
   Page 32
4. How will Medicare audit the new CPT codes?
   Page 42
5. How do the contributory components (coordination of care, counseling, nature of the presenting problem and time) affect my level of care decision?
   Page 29-30
6. When will Medicaid and other private insurers accept the new codes?
   Page 33
7. Will there be seminars to help with the transition?
   Page 17

Continued on next page

YOCON®
YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Continued from preceding page

Global surgery

1. If I perform several surgical procedures at the same time on a patient, how will I be reimbursed?
   Page 37
2. I frequently assist at surgery. How will Medicare calculate my fee?
   Page 37
3. I live in a rural area and my patients frequently have surgical procedures performed elsewhere and return home for post-operative recovery. What will my reimbursement be for providing office post-operative care?
   Page 37
4. What is included in the global surgery package for major surgery?
   Page 34
5. Are minor surgical and endoscopy procedures subject to a global package?
   Page 35
6. Are there services which can be billed separately from the global surgery package?
   Page 34-35
7. When I perform a single surgical procedure on both sides of the body, will I be reimbursed for both procedures?
   Page 37
8. In our clinic, the surgeon may perform a procedure, and the internist may follow the patient for post-operative care. Do we need to bill separately for these services even though we bill under a clinic provider number?
   Page 37
9. If I am performing office post-operative care, and my patient needs care for a problem not related to the surgical procedure that was performed, how can I bill for this service?
   Page 35

Miscellaneous

1. Where can I purchase a new CPT-4 book?
   Page 14
2. I frequently have questions regarding Medicare. To whom should I write at WPS-Medicare?
   Page 14
3. How was the RBRVS program developed?
   Page 18
4. Do I still need to use type of service codes after Jan 1?
   Page 39
5. I have heard that place of service codes are changing. Is this true?
   Page 40
6. How are EKG interpretations paid under the RBRVS?
   Page 39
7. If I don't have a UPIN number, what should I do?
   Page 40
8. Will my claim be denied if the ICD-9 code is not correct?
   Page 42
9. Will Medicare pay for surgical trays under the RBRVS?
   Page 41
10. Do I need to complete CMN forms for durable medical equipment my patients need?
    Page 41
11. When is the new HCFA 1500 (12-90) claim form required for Medicare?
    Page 41
12. How long will it take Medicare to process an informal review in 1992?
    Page 42

WMJ Writing Contest

Awards: $500, publication in the *WMJ*, and presentation of a certificate at the SMS annual meeting. Two awards are granted: one student, one resident.

Eligibility: Contestants must either be students enrolled in a Wisconsin medical school or residents practicing in Wisconsin.

Deadline: Papers must be received by the *WMJ* by Feb. 14, 1992: PO Box 1109, Madison, WI 53701.

Rules: Papers must be typewritten, double-spaced with 1-inch margins, and no longer than 10 pages. Topics must fall within the parameters of scientific medicine. The *WMJ* editorial board serves as the panel of judges and has final authority.

Criteria: scientific merit, applicability, content, innovation and writing ability.

Contact the *WMJ* for further details.

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Resource directory

THIS RESOURCE GUIDE will help you contact the appropriate organizations for information and materials about the changes which will occur in physicians' billing practices in 1992.

Organizations

- State Medical Society of Wisconsin
  PO Box 1109
  Madison, WI 53701
  (608) 257-6781 or (800) 362-9080

Topic of inquiry	*Division*
Coding	Medical Policy and Practice
Medicare forms	SMS Holdings
Medicare, general	Medical Policy and Practice
Medicare Medical Policy Advisory Group	Medical Policy and Practice
Seminars	Medical Policy and Practice

- WPS-Medicare
  PO Box 1787
  Madison, WI 53701
  (608) 221-3218, Customer Service

You may either call or write WPS-Medicare. If you call, you will access WPS-Medicare's automated voice response unit (ARU) telephone inquiry response system, unveiled in October 1991. It is designed to provide faster responses to routine calls. The system provides ongoing instructions to help callers obtain information they need. To access the system, the ARU requires you to enter nine digits when entering your Medicare provider number. You must precede the five-digit number with four zeros. Example: If your provider number is 57341, you must enter 000057341 when the ARU requests this information.

When entering the date of service information, the ARU requires six digits (eg, to enter Oct 2, 1990, punch in 100290). Detailed instructions for using the ARU are available in the August 1991 issue of WPS' *Communique*.

All provider calls are now processed through the AUR, which is available from 7 am to 9 pm, Monday through Friday. Customer service representatives can be reached by following the instructions given by the ARU, and are available from 7:30 am to 4:30 pm weekdays.

If you write WPS-Medicare, you should address your correspondence as follows:

Topic of inquiry	*Responsible unit*
Status (resubmissions and tracers)	Customer Service
General questions	Customer Service
Incorrect claims processing	Customer Service
Deductible problems	Customer Service
Review requests	Informal Review
Durable medical equipment review requests	DME Unit
Fair hearing request	Fair Hearing
Release of information under the Freedom of Information Act (FOIA)	FOI Unit
Complex billing problems	Provider Education
Provider number information	Central Provider Control
Abuse and fraud issues	Program Integrity
Communique copies	Customer Service
Electronic claim information	Paperless Claims
Fee information	Reimbursement

Resource materials

- Medicare Part B Reference Manual
  (written by SMS and WPS-Medicare as a guide for submitting Medicare claims)
  State Medical Society of Wisconsin, Attn: MPP
  PO Box 1109, Madison, WI 53701
  $25 + tax

- Laminated grids for new CPT-4 codes
  State Medical Society of Wisconsin, Attn: MPP
  PO Box 1109, Madison, WI 53701
  $2 per grid + tax; two grids available; one for outpatient services and the other for inpatient services; may be ordered in bulk at the same price

- CPT-4 coding books
  American Medical Association, Order Department
  PO Box 109050, Chicago, IL
  (800) 621-8335; FAX (312) 464-5600 for credit card orders
  Soft sover: $27 members, $34 nonmembers

- ICD-9-CM code books
  Superintendent of Documents
  Government Printing Office
  Washington, DC 20402-9325
  (202) 783-3238

  ICD-9-CM
  PO Box 971, Ann Arbor, MI 48106
  (313) 930-7830

  American Medical Association, Order Department
  PO Box 109050, Chicago, IL 60610
  (800) 621-8335; FAX (312) 464-5600 for credit card orders

Continued on page 17

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St. Mary's Hospital, Madison, WI

Memorial Hospital of Iowa County, Dodgeville, WI

St. John's Northeast Hospital, Maplewood, MN

Abbott Northwestern Hospital, Minneapolis, MN

Midway Hospital, St. Paul, MN

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☐ General Surgery ☐ Neurology ☐ Urology ☐ Orthopedics

☐ Surgical Lights for:
☐ General Surgery ☐ Outpatient Surgery ☐ Birthing Room Lighting System

☐ Renovation/remodeling is planned for:
☐ 1-6 months ☐ 12+ months ☐ 7-12 months ☐ recently completed

Contact This Individual (Name/Title) _____

Firm/Organization _____

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Continued from page 14

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Med-Index Reimbursement Publications
PO Box 536180, Salt Lake City, UT 84152-6180
(800) 999-4600

St Anthony's Publications
PO Box 14212, Washington, DC 20044
(800) 632-0123

- HCPCS Level II code books
  Government Printing Office
  (202) 783-3238
  Request HCPCS Hard Copy, Stock #0017-060-00418-5
  Cost: $16 (MasterCard or Visa)

- UPIN directories
  WPS-Medicare, FOI Unit
  PO Box 1787, Madison, WI 53701
  One free directory issued for each provider number.

Government Printing Office
Building 3, Room 3836, Washington, DC 20401
(202) 275-0186
Stock # 017-060-00456-8
Cost: $15

- *Federal Register*-RBRVS final rule
  (This can also be ordered from the SMS, along with the AHPB. See further instructions on next page.)

  Government Printing Office
  Order and Information Desk, Washington, DC 20302-9329
  (202) 783-3238
  Specify issue for Nov 25, 1991, and stock #069-001-00037-8
  Cost $1.50

Other resources

Seminars

The SMS has scheduled numerous seminars beginning in

Continued on next page

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AIR FORCE

Continued from preceding page
January on coding and on Medicare policies and procedures. For a complete calendar of seminars for 1992, contact the Division of Medical Policy and Practice: (608) 257-6781, ext. 228 or (800) 362-9080, ext. 228.

Medicare reform education series video tapes
A series of three video tapes to help you and your medical staff understand and implement the changes under RBRVS have been developed by the Wisconsin Medical Group Management Association, in cooperation with the Marshfield Clinic, the SMS, and WPS-Medicare. The series addresses the new CPT evaluation and management codes, global surgery rules, and other policy changes. Each tape is approximately 30 minutes and written by physicians with accurate and up-to-date information. Information on ordering the series, or single tapes, is available in *Medicare Alert*, a *Medigram* insert.

RBRVS final rule and AHPB data
Copies of the RBRVS final rule from the Nov 25 *Federal Register*, and the Adjusted Historical Payment Basis (AHPB) are available for purchase from the SMS at the cost of copying and mailing. The information from the *Federal Register* includes Addendum B, which contains the relative value units, and Addendum C, which contains the geographic practice cost indices.

If you want to calculate your fee schedule amounts to verify information on your fee schedule disclosure, you will need Addendums B and C, and the AHPB. Order forms are available in recent issues of *Medicare Alert*, a *Medigram* insert. See also the section calculating fees for 1992 on page 25.

The history and future of the RBRVS, in brief

Often, change makes more sense when placed in context. Without it, how we arrive at a certain point may seem unfathomable. The implementation of RBRVS this year culminates what has been a decade-long process during which physicians were faced with stiff challenges to their practice traditions and to fee-for-service medicine. Whether 20-20 hindsight would have brought us to this same point is impossible to predict. Yet, looking back, when Congress overhauled hospital payment with DRGs, physician DRGs and capitation were being discussed. The RBRVS was accepted by the medical profession as the best alternative because it maintained the fee-for-service structure and addressed payment inequities recognized by the profession as irrational and distorted, and would eventually result in a simpler and more uniform system.

The road to RBRVS

1979
William Hsiao, PhD, of Harvard School of Public Health and lead researcher in the development of RBRVS, completes the first attempt at developing a payment formula based on resource costs.

1980-1982
Primary care specialties argue for better pay for cognitive services. Federal officials look at Medicare fee schedules.

1983
Massachusetts Rate Setting Commission promulgates Medicaid regulations based on Dr Hsiao's 1979 methodology and contracts with him to develop a more sophisticated version of the study.

1983-1984
Congress overhauls hospital payment and turns to physician payment reform, calling 1984 the "year of the physician." The Reagan administration pursues "packaged" payment methods, including physician DRGs and mandatory capitation. AMA debates reform.

1985
Dr Hsiao releases results of refined study for Massachusetts. Congress mandates that the Department of Health and Human Services develop a relative value scale for Medicare Part B. HCFA contracts with Dr Hsiao for an additional study, with the AMA as a subcontractor working with Dr Hsiao and allowing for AMA and specialty consulting groups to provide assistance in developing the schedule.

1988
Dr Hsiao submits the RBRVS report to HCFA and receives another contract for additional study. AMA endorses the Harvard study with the understanding that further refinement is necessary.

1989
Congress adopts RBRVS as the new payment formula for physician services.

June 1991
HCFA is criticized by doctors, Congress, and the Physician Payment Review Commission (PPRC) for promulgating rules with a 16% slash in average payments. Legislation is introduced to restore cuts. Physicians respond in unprecedented numbers and gain support of Congress.

Nov 1991
HCFA promulgates final rule. Payment cut is reduced to a 6.5% payment reduction to the conversion factor.

The 1989 Congressional act to adopt RBRVS included the following provisions:

- required Medicare to adopt a standardized schedule of payments for physician services using a resource-based relative value scale;
- prohibited specialty payment differentials for the same service;
- required a budget neutral conversion factor which translates the relative value for a service into a dollar reimbursement;
- established a process for updating the conversion factor each year and established the Medicare Volume Performance Standard, which if exceeded by physicians

Continued on next page

LYME DISEASE INFORMATION: THREE COMPREHENSIVE BOOKLETS

1) The **Lyme Times** (F/S 1991, Vol. 2, #2, 40 pages); Treatment discussions and survey by MD's Daniel Rahn, Stephen Malawista, Paul Lavoie, Audrey Stein Goldings, Kenneth Liegner, Dorothy Pietrucha, Joseph Burrascano, and James Katzel; and DC Alec M. Isabeau; reports of new tests, upcoming conferences, NJ political success story, resources; LBF hotline; national support/ resource group list; Linda Hanner's *When You're Sick And Don't Know Why* review.
2) **Handbook on Lyme Borreliosis** (Fourth Edition, June, 1991) 36 pages. Historical aspects of B. burgdorferi; updated portions of the Clinician's Guide (Wisconsin DHSS, 1989); CDC criteria for reporting; culture and sensitivity tests; treatment table from Medical Letter 1989; selected papers of MD's Joseph Burrascano and Dorothy Pietrucha from 1990 LB Scientific Symposium; brief summary of 1991 LBF Symposium. (Editor, Wendy P. Feaga, D.V.M., Maryland Lyme Support Group, 13151 Triadelphia Road, Ellicott City, Maryland 21042).
3) **Lyme Treatment News** (1991 issues, plus excerpt of editor Richard Lynch book ms., 35 pp.) Proposes investigation of alternative treatments with Physician's Consortium and Lyme Buyer's Club. Monthly. Subscription...$20/yr. includes all back issues, from LTN, 17 Monroe Ave., Staten Island, NY 10301; 718-273-3740.

Each booklet is 8.5" X 11" on white paper with heavier green cover and saddle-stapled. Price chart for either booklet, or any combination of booklets: 10 copies...$20; 50 copies...$60; 100 copies...$100; 1000 copies...$750. **Special: one of each for $10.** Order directly from and make checks payable to:

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Continued from preceding page

as a whole during a given year will result in a reduction in the conversion factor update;

- imposed stringent limits on balance billing; and
- described how the relative value for each service is to be adjusted for geographic difference in resource costs.

HCFA's November 1992 final rule on RBRVS addressed the following RBRVS implementation issues:

- established relative value units (RVUs) for the more than 7,000 codes for physician services, including RVUs for the new CPT-4 visit codes;
- set the 1992 conversion factor at $31.001;
- set the Medicare Volume Performance Standard for 1992 at 11.2% for non-surgical services and 6.5% for surgical services, against which HCFA will compare actual 1992 expenditures for setting future updates;
- established a number of surgical policies on global surgery, minor surgery and non-incisional procedures, multiple surgery, bilateral surgery, assistant-at-surgery, co-surgery, and team surgery;
- provided for separate payment per visit for each nursing home patient;
- expanded the new physician reduction to include those practicing in group settings;
- identified a list of procedures for which supplies will be paid independently;
- established payment for drugs at the lower rate, either 100% of estimated acquisition cost or average wholesale price;
- set forth a reduction in payment for services performed in outpatient departments rather than in the physician office;
- supported an earlier Congressional act for prohibiting separate payment for EKG interpretations performed as part of or in conjunction with a visit or consultation;
- maintained anesthesia payment based on actual time;
- integrated the current radiology fee schedule into the overall physician fee schedule;
- established relative values for pathology codes and a new category of service for clinical laboratory interpretation services; and
- provided for a 120-day comment period on all of the RVUs.

As noted in the final point directly above, physicians have the opportunity to comment on the RVUs published in the rules. Comments must be addressed to: Health Care Financing Administration, Department of Health and Human Services, Atten: BPD-712-F, PO Box 26688, Baltimore, MD 21207. Comments are due by March 30, 1992. For information on obtaining a copy of the RBRVS final rule, which contains the RVU schedule, please see the "Resource directory" on page 18.

This opportunity for comment is indicative of a process which has only just begun, that of refining the RBRVS to ensure that its application meets the goals set forward in terms of providing a rational, reasonable system for valuing physician services. Under debate are several proposals, including one developed by the AMA as a joint AMA/specialty society process, for updating the relative value schedule. Additionally, physicians and their organizations, through their overwhelming grassroots response to the proposed rules, have garnered significant support in Congress and will have to decide whether to seek legislative relief on outstanding issues of particular concern.[150th]

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Physician fees under the RBRVS

THE RBRVS ESTABLISHES a total relative value unit or RVU for every service code which is based on a measurement of resources required to provide the service. This measurement includes physician work, practice expense, and malpractice costs associated with the service. Each of these components is then multiplied by a geographic practice cost index (GPCI, or "gypsy") to establish the final locality-specific RVU. The resource measurements are based on the following components:

- physician work (the amount of time spent performing the service; pre and post time; and the required mental effort, technical skill, knowledge-judgment-diagnostic skills, physical effort, psychological stress due to uncertainty, and potential risk to the patient or physician);
- practice expense (the overhead required when performing a service including such costs as office space, employee wages and equipment); and
- malpractice (the malpractice costs associated with performing the service).

The RBRVS formula

$(TW \times GPCI_1) + (PE \times GPCI_2) + (MP \times GPCI_3)$ = Total RVU for a given service and locality

TW = total work input by the physician
PE = practice expense associated with a service
MP = malpractice costs associated with a service

$GPCI_1$ = Geographic Practice Cost Index for total work
$GPCI_2$ = Geographic Practice Cost Index for practice expenses
$GPCI_3$ = Geographic Practice Cost Index for malpractice costs

The GPCIs measure the relative differences across geographic regions in the cost of a "market basket" of those items required to run a private physician practice.

Final RVUs, therefore, are both service and locality specific. Once the number of value units is established for a given locality specific service, a dollar conversion factor is applied to determine actual Medicare payment. This calculation is correct only for fees moving directly to the RBRVS fee schedule immediately in 1992. See page 25 for complete instructions on calculating all 1992 fees.

The 1992 conversion factor is $31.001. Example:
99202 office visit for new patient for La Crosse
Final RVU = (.77 x .976) + (.49 x .919) + (.05 x .762) = 1.24
1.24 x $31.001 = $38.44

The 1992-1996 transition to the RBRVS

Not all fees move immediately in 1992 to the amounts that would be determined by the RBRVS formula. It was recognized in establishing the system that a transition period was essential to provide physicians with time to adjust to the changes in Medicare reimbursement. The transition will continue from 1992 until 1996 and will be based on different calculations for each year. (For further information, please see the article on how fees are derived, on page 24.)

Understanding the Medicare fee schedule disclosure

THE PHYSICIAN specific fee schedule disclosure replaces the provider pricing profile that was used under the old "customary, prevailing and reasonable charge" system. Provider pricing profiles are no longer necessary under RBRVS because the individual physician's historical charge data is no longer used to determine physician fees.

Established physicians

WPS-Medicare mailed the following information to established physicians: a physician specific fee schedule disclosure listing the fee amounts (previously called the approved amounts) for participating and non-participating physicians for the new CPT evaluation and management codes, as well as for codes traditionally billed by the physician, and the limiting charge for these codes. The limiting charge is the maximum amount non-participating physicians may balance bill their patients.

Some codes on the physician specific fee schedule disclosure are listed with more than one fee amount. These represent codes which are subject to a reduction when performed in an outpatient setting. On the physician specific fee schedule disclosure, the first set of fees are applicable when the service is performed in an office setting. The second set of fees, identified by an *, are the reduced fees to be used when the service is performed in an outpatient setting. The services affected are those which have been identified by HCFA as services predominately performed (at least 50% of the time across the nation) in physician of-

fices. Therefore, when performed in an outpatient setting, the practice cost component (which includes office rent, equipment, employee wages, etc) for that service is reduced by 50%. The effect on the total fee is a reduction of approximately 21%.

Physicians who anticipate providing new services during 1992 for which there are no codes listed on their physician specific fee schedule disclosure should request an all locality fee schedule disclosure. (If you believe a procedure code should be listed on your physician specific fee schedule disclosure because of previous billings and it does not appear there, write to WPS-Medicare, Reimbursement Unit, PO Box 1787, Madison, WI 53701.) WPS-Medicare will provide one copy of the all locality fee schedule disclosure free of charge, and additional copies for a charge. This information can be obtained by writing to WPS-Medicare, Freedom of Information, at the above address. The all locality fee schedule disclosure is approximately 355 pages. It provides the participating fee amounts for all CPT codes in all localities in Wisconsin. Non-participating fees are 95% of the participating fee, and must be calculated from the information provided. The limiting charge for services not previously billed by the physician is 120% of the non-participating fee.

New physicians

Physicians who are in their first 4 years of practice are considered new physicians by Medicare. The first year of practice is defined as the first full calendar year during which the physician is in practice from January to June and begins when the first Medicare claim is filed. For example, if a physician begins practice in March 1992 and files the first Medicare claim in March, the first year of practice will be March 1992 through December 1993. The second, third, and fourth years are based on calendar years. Under RBRVS, all new physicians are subject to reductions in payment. The new physician fees will be as follows: 80% in the first year; 85% in the second year; 90% in the third year;

Continued on next page

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Continued from preceding page
95% in the fourth year.

The information provided by WPS-Medicare to new physicians includes the following: a letter informing the physician of their designated year of practice, a fee schedule disclosure listing the participating and non-participating fee amount for the new evaluation and management CPT codes and for codes traditionally billed by that physician, and the limiting charges for these codes. Please refer to the information found in the established physician's section above on how to read the fee schedule disclosure. A newly practicing fee schedule disclosure listing the appropriate adjusted fee amount for each of the first 4 years of practice is also included. Non-participating new physicians must calculate their fee and limiting charge from the newly practicing fee schedule disclosure for codes not listed on their physician specific fee schedule disclosure. The non-participating fee for new physicians is 95% of the participating fee for the corresponding year of practice. The limiting charge is 120% of the non-participating fee for the corresponding year of practice. New physicians do not need to request the all locality fee schedule disclosure because the newly practicing fee schedule disclosure provides information on all of the codes for their locality.

Independently practicing new physicians should have received their physician specific fee schedule disclosure and a copy of the newly practicing fee schedule disclosure. Clinics should have received one copy of the newly practicing fee schedule disclosure.

On Oct 25, 1991, WPS-Medicare mailed letters of inquiry to clinics requesting updated information about new physicians. If no response was received to the inquiry, WPS-Medicare assumed that their own records are correct. If it appears that an error has been made in the practice year for new physicians, call the Customer Service Unit at WPS-Medicare, (608) 221-3218, or write to the Central Provider Control Unit, WPS-Medicare, PO Box 1787, Madison, WI 53701, to resolve the problem.

How fees are derived

The information on the physician specific fee schedule disclosure represents the calculations made by WPS-Medicare for the 1992 fees. The calculations of fees for 1992 through 1996, at which time RBRVS will be fully implemented, are based on what are called "transition formulas" which are different for each year of the transition. For every service in every locality, a number called the "adjusted historical payment basis" (AHPB) has been derived. The AHPB combines the prevailing charge data for all specialties in a given locality and is the basis for the transition formula. For every service in every locality, there is also the fee developed through the RBRVS formula based on total physician work, malpractice expense, and practice expenses. For 1992, if the AHPB is neither 15% higher, nor 15% lower than the RBRVS fee, services will automatically transit to the RBRVS fee schedule amount. Services which are less than 85% or more than 115% will be increased or decreased from the AHPB by 15% of the RBRVS fee, and therefore represent the "transition fee" for 1992. For example, if the AHPB is $200 and the RBRVS fee is $100, the 1992 transition fee for participating physicians is: $200 - $15 ($100 X 15%) = $185. The non-participating physician transition fee is 95% of $185. All physicians who provide a particular service in a given locality will receive the same fee for that service (according to their participation status), with the exception of "new physicians." Medicare will reimburse 80% of the amount on the physician specific fee schedule disclosure due to the 20% co-pay requirement which remains.

See page 25, "Calculating fees for 1992," for detailed information on how you can calculate specific fees to verify the amounts on your physician specific fee schedule disclosure. Alternatively, questions regarding the calculation of the fee amounts and the physician specific fee schedule disclosure may be addressed, in writing, to: WPS-Medicare, Reimbursement Unit, PO Box 1787, Madison, WI 53701.

Calculating fees for 1992

YOUR FEES FOR 1992 have been calculated for you by WPS-Medicare. The fee schedule disclosures which were mailed to physicians were the final result of these calculations. The new fee schedule disclosures replace the traditional provider pricing profiles, which have been the historical means of notifying physicians of their Medicare charge information. The article on page 22, "Understanding the Medicare fee schedule disclosure," provides detailed information on how to interpret your physician specific fee schedule disclosure.

You may have questions regarding the fees which appear on your disclosure. It is possible for you to verify the accuracy of the fees. To do so, you will need the following data (See the "Resource directory" on page14):

- the relative value unit schedule, printed as part of the RBRVS final rule in the Nov 25, 1991, issue of the *Federal Register*, which indicates the relative value units for each of the work, practice cost, and malpractice components of the service;
- the schedule of geographic practice cost indices (GPCIs) from the Nov 25, 1991, *Federal Register*; and
- the adjusted historical payment basis (AHPB) for your locality.

The following calculations should result in the same participating payment rate as appears on the physician specific fee schedule disclosure and on the all locality fee schedule disclosure. (A complete numeric example of these calculations follows on page 26.)

Components of service:	RVUs from *Federal Register*	(multiplied by GPCI for your locality)		
1. Work	_____	X _____	=	_____
2. Practice cost	_____	X _____	=	_____
3. Malpractice	_____	X _____	=	_____

From Addendum B of the *Federal Register*, locate the procedure code and fill in the appropriate relative value units (RVUs) on lines 1, 2 and 3. From Addendum C, fill in the appropriate geographic cost index (GPCI) values on lines 1, 2 and 3 for the Medicare locality in which you are located. A list of Wisconsin Medicare localities can be found at the end of this article. Multiply across RVUs x GPCIs.

4. Add totals from lines 1, 2 and 3 ..... = _____

5. Multiply total from line 4 by the 1992 conversion factor ($31.001) ..... = _____
   The product from step 5 is the 1992 RBRVS payment rate. Additional calculations are needed to determine if fee is subject to the 1992 transition formula. (See page 24 for explanation of transition.)

6. Next, select from the AHPB listing the adjusted historical payment basis for the service and compare it to the RBRVS rate you obtained from step 5:

   _____ divided by _____ = _____ %
   adjusted historical payment basis — 1992 RBRVS rate — difference

7. If the difference between your adjusted historical payment basis and the 1992 RBRVS rate is 85% to 115% in step 6, the amount indicated on your fee schedule disclosure will be the same as the 1992 RBRVS rate from step 5.

8. If the difference between your adjusted historical payment basis and the 1992 RBRVS rate is 84% or less in step 6, the amount on your fee schedule disclosure is a transition fee for 1992. The transition fee is the adjusted historical payment basis plus 15% of the 1992 RBRVS rate:

   Calculate:

   _____ + _____ = _____
   adjusted historical payment basis — (1992 RBRVS rate x .15) — 1992 transition fee

Continued on next page

Continued from preceding page

9. If the difference between your adjusted historical payment basis and the 1992 RBRVS rate is 116% or more in step 6, the amount on your fee schedule disclosure is a transition fee for 1992. The transition fee is the adjusted historical payment basis minus 15% of the RBRVS rate:
   Calculate:

_____	-	_____	=	_____
adjusted historical payment basis		(1992 RBRVS rate x .15)		1992 transition fee

Note: For radiology, use 9% instead of 15% in steps 8 and 9

The above calculations will determine the payment rate for participating physicians.

The payment rate for non-participating physicians is 95% of the rate for participating physicians. Continue on for calculations on the limiting charge. (Note: For the CPT-4 codes which have changed for 1992, you will not be able to complete this calculation. See "The new CPT-4 codes," on page 29. You can address your questions in writing to WPS-Medicare, Reimbursement Unit, PO Box 1787, Madison, WI 53701.)

The 1992 limiting charge for non-participating physicians is determined on the same basis as the 1991 limiting charge. It is the same percentage, not to exceed 20%, above the 1992 payment rate for non-participating physicians as the percentage by which a physician's 1991 limiting charge exceeded the 1991 prevailing charge for non-participating physicians.

The following calculations can be made to verify your limiting charges:

1. Determine the 1992 non-participating (nonpar) fee.

_____	x	.95	=	_____
1992 fee for participating physicians		nonpar % reduction		nonpar 1992 fee payment amount

2. Compare the 1991 limiting charge to the 1991 nonpar prevailing charge, utilizing data from your 1991 provider pricing profile.

_____	divided by	_____	=	_____	%
1991 limiting charge		1991 nonpar prevailing charge		difference	

3. The limiting charge on your 1992 fee schedule disclosure will be the lower of:

   A. The 1992 nonpar fee payment amount multiplied by the difference between the 1991 limiting charge and the 1991 nonpar prevailing charge. Step #1. X. step #2 = limiting charge

   or

   B. 120% of the 1992 nonpar fee amount. Step #1. X. 1.20 = limiting charge

Example I

Following is a specific example. Working through this in conjunction with the *Federal Register* fee schedule will help you complete your own calculations. While you will also need the AHPB to complete your calculations, the AHPB is locality-specific and yours may differ from that used here.

CPT Code 49505 - Repair inguinal hernia. Locality 40–Northeast Wisconsin

Components of service:	RVU from schedule.	(multiplied by)	GPCI for your locality	
1. Work	5.08	X	.979	= 4.97
2. Practice cost	4.75	X	.913	= 4.34
3. Malpractice	.99	X	.762	= .75

4. Add totals from lines 1, 2 and 3 . . . . . .= 10.06

5. Multiply total from line 4 by the 1992 conversion factor ($31.001) . . . . . .= $311.87
   The product from step 5 is the 1992 RBRVS payment rate.

6. Next, compare your 1992 adjusted historical payment basis for the service to the RBRVS rate you obtained from step 5:

$392.26 adjusted historical payment basis	divided by	$311.87 1992 RBRVS rate	=	1.26 % difference

The result in step 6 indicates a 126% difference which, because this is "116% or more," directs you to step 9.

9. If the difference between your adjusted historical payment basis and the 1992 RBRVS rate is 116% or more in step 6, the amount on your fee schedule disclosure is a transition fee for 1992. The transition fee is the adjusted historical payment basis minus 15% of the RBRVS rate:

Calculate:

$392.26 Adjusted historical payment basis	divided by	($311.87)(.15) = $46.78 (1992 RBRVS rate x .15)	= $345.48 1992 transition fee

The following calculations can be made to verify the non-participating payment rate and the limiting charge:

1. Determine the 1992 non-participating fee.

$345.48 1992 fee for participating physicians	x	.95 nonpar % reduction	=	$328.21 nonpar 1992 fee payment amount

2. Compare the 1991 limiting charge to the 1991 nonpar prevailing charge, using data from your 1991 provider pricing profile. (Note: Data used for this calculation is not actual data. You will need to use specific data off your 1991 profile.).

$490.00 1991 limiting charge	divided by	$415.25 1991 nonpar prevailing charge	=	118 % difference

The limiting charge on your 1992 fee schedule disclosure will be the lower of:

step #1 X step #2

or

step #1 X 120%

In the above example, 118% is lower than 120%. Therefore, the limiting charge is 118% of the non-participating fee payment amount: $328.21 X 1.18 = $387.29 (limiting charge).

Wisconsin localities

Loc 04
01 Milwaukee
02 Milwaukee
73 Milwaukee

Loc 12
04 Ashland
05 Barron
06 Bayfield
09 Burnett
12 Clark
18 Douglas
28 Iron
49 Polk
51 Price
55 Rusk
58 Sawyer
61 Taylor
66 Washburn

Loc 13
03 Adams
13 Columbia
26 Green Lake
31 Juneau
41 Marquette
42 Monroe
70 Waushara

Loc 14
14 Crawford
24 Grant
27 Iowa
35 LaFayette
53 Richland
57 Sauk
63 Vernon

Loc 15
15 Dane
74 Dane

Loc 19
08 Buffalo
11 Chippewa
19 Dunn
20 Eau Claire
29 Jackson
34 LaCrosse
47 Pepin
48 Pierce
56 St. Croix
62 Trempeleau

Loc 36
36 Langlade
37 Lincoln
39 Marathon
44 Oneida
50 Portage
64 Vilas
72 Wood

Loc 40
07 Brown
17 Door
21 Florence
23 Forest
33 Kewaunee
40 Marinette
43 Oconto
45 Outagamie
59 Shawano
69 Waupaca

Loc 46
32 Kenosha
46 Ozaukee
52 Racine
67 Washington
68 Waukesha

Loc 54
16 Dodge
25 Green
30 Jefferson
54 Rock
65 Walworth

Loc 60
10 Calumet
22 Fond du Lac
38 Manitowoc
60 Sheboygan
71 Winnebago

Loc
80 ROS-osteopaths
81 ROS-Podiatry
04 MILW-Podiatry
81 ROS- Ind Lab
04 MILW-Ind Lab
81 ROS-Port X-ray
04 MILW-Port X-ray
76 SW-Dentists
81 SW-Optometrists
81 ROS-DME
04 MILW-DME
81 SW-Ambulance
75 ROS-Chiropractor
04 MILW-Chiropractor
81 ROS-Licensed Physical Therapist
04 MILW-Licensed Physical Therapist
81 ROS-Mental Health Clinic
04 MILW-Mental Health Clinic

ROS-Rest of State-excluding Milwaukee County
MILW-Milwaukee County
SW-Statewide

04 thru 60 Statewide Physicians and Milwaukee County Osteopaths

150th

The new CPT-4 codes

THE CPT-4 CODES of the 90000 series, which are mainly visit codes, changed Jan 1, 1992. The new codes are similar to the old codes in that both include broad categories of visits such as office visits, hospital visits and nursing home visits. Some of the broad categories will be further broken down into new patient and established patient subcategories. The services described by the new codes are called evaluation and management (E/M) services. In addition to reviewing how to use the most common of these new codes, this section highlights other 1992 coding changes and provides instructions on when you must begin using the new codes.

Listed below are the new E/M service codes:

Category or subcategory	Code numbers
Office or other outpatient services	
New patient	99201-99205
Established patient	99211-99215
Inpatient hospital services	
Initial hospital care	99221-99223
Subsequent hospital care	99231-99233
Hospital discharge services	99238
Consultations	
Office consultations	99241-99245
Initial inpatient consultations	99251-99255
Follow-up inpatient consultations	99261-99263
Confirmatory consultations	99271-99275
Emergency department services	99281-99285, 99288
Critical care services	99291, 99292
Nursing facility (nf) services	
Comprehensive nf assessments	99301-99303
Subsequent nf care	99311-99313
Domiciliary or rest home services	
New patient	99321-99323
Established patient	99331-99333
Home services	
New Patient	99341-99343
Established Patient	99351-99353
Case management	
Team conferences	99361-99362
Telephone calls	99371-99373
Preventive medicine services	
New patient	99381-99387
Established patient	99391-99397
Individual counseling	99401-99404
Group counseling	99411-99412
Other	99420-99429
Newborn care	99431-99440
Other E/M services	99499

Why a change is needed

The CPT-4 codes are developed by the AMA through the CPT Editorial Panel and Advisory Committee. The editorial panel members stated that new codes, which would more accurately quantify physician work, were needed to ensure appropriate valuation of services within the RBRVS framework. Additionally, survey results of Medicare claims data indicated physicians throughout the country were interpreting and using the old coding system differently. The new codes are clinically more detailed, taking into account the extent of the history required, the level of physical examination, and the complexity of making medical decisions. The editorial panel members stated that the new codes, once learned, will be easier for physicians and staff to use.

How to use the new codes

This section contains two very helpful grids, developed by the Marshfield Clinic Reimbursement Committee and staff, that can be used by physicians in determining the appropriate codes for the following types of most common services: office or other outpatient services; inpatient hospital services; and consultations. Before turning to the grids, the following section describes, in general, how the new E/M codes are set up.

The E/M codes are assigned by correctly classifying three key components of the service: level of history, level of physical examination, and complexity of medical decision-making. The history and physical examination components are classified as being either problem focused, expanded problem focused, detailed or comprehensive levels. The component of medical decision-making complexity is classified as: straight forward, low, moderate or high complexity. Each of the classifications have definitions. For example, a problem focused examination is defined as "an examination that is limited to the affected body area or organ system." A detailed examination is defined as "an extended examination of the affected body area(s) and other symptomatic or related organ system(s)." All of the needed definitions are presented later in this article.

In addition to the three key components, the CPT-4 lists four contributory components that may be considered but are not required to assign the correct codes. The contributory components include: severity of the presenting problem, counseling, coordination of care and time.

With one exception, time factors included in the E/M codes are only guidelines, to assist physicians in selecting the most appropriate E/M level of service. Times listed are averages, and the real time involved in any given service may be higher or lower depending upon the practitioner and the circumstances.

Time determines the code used when counseling or coordination of care takes up more than 50% of the face-to-face physician-patient encounter for outpatients or more than 50% of the unit or floor time for inpatients. The encounter is coded according to the amount of time involved and the time listed within each CPT code, rather than the actual services provided. The extent of counseling or coordination of care (not just the time factor) must be documented in the record to substantiate the code choice.

Counseling is defined as discussion concerning patient care with the patient or family. This may include explanations of diagnostic results, impressions or recommended studies, prognosis, risks and benefits of various treatment options, instructions for management or follow-up, importance of compliance with chosen treatment options, risk factor reduction or patient and family education.

The new E/M codes and the old visit codes cannot be cross-walked because the decision-making criteria for the new codes is completely different from that of the old codes. Accurate coding is essential for correct third-party payor reimbursement. Attempts to cross-walk the old and new codes will result in coding errors that will cause delays and denials of claims.

Grids for outpatient, inpatient and consultation services

The grids presented below will be valuable tools for physicians in understanding and using the new codes for outpatient, inpatient and consultation services. (These grids are available for purchase, at the cost of reproduction, through the SMS in pocket-sized three-fold laminated brochures. See the "Resource directory" on page 14.) The first grid is to be used for office and other outpatient services, consultations (except for follow-up inpatient consultations) and ER. The second grid is to be used for all inpatient visits and inpatient follow-up consultations.

In looking at the first grid for office and other outpatient services, consultations (except for follow-up inpatient consultations) and ER, it is divided into two parts, one for new patients, consultations, and ER, and the other for established patients. The top three rows incorporate the three key components of assigning the codes including history, physical examination and complexity of medical decision-making. In reading across the history row, the level of history progresses from problem focused to comprehensive for new patients, consultations and ER. Similar progressions are noted in the other rows as well. Instructions on how to use the grids and definitions for all of the different levels are provided below the first grid. The Roman numerals at the bottom of the grids indicate the appropriate code. For example, office or other outpatient established codes range from 99211 to 99215, with 99211 indicating a level I service, 99212, level II service, and so on.

Before proceeding, please take a few minutes to review the grids and the definitions.

For office and other outpatient services, consultations (except follow-up inpatient consultations), and ER.

Outpatient/Consult/ER	New/Consults/ER					Established				
History	Problem focused	Expanded problem focused	Detailed ER: Exp. prob.foc.	Comprehensive ER:Detailed	Comprehensive	*Minimal problem that may*	Problem focused	Expanded problem focused	Detailed	Comprehensive
Physical examination	Problem focused	Expanded problem focused	Detailed ER:Exp. prob.foc.	Comprehensive ER:Detailed	Comprehensive	*not require presence*	Problem focused	Expanded problem focused	Detailed	Comprehensive
Complexity of medical decision	Straightforward	Straightforward ER:Low	Low ER:Low to moderate	Moderate	High	*of physician*	Straightforward	Low	Moderate	High
Severity of condition	Self-limited/minor	Low to moderate	Moderate	Moderate to high ER:High	Moderate to high ER:High	Minimal	Self-limited/minor	Low to moderate	Moderate to high	Moderate to high
Average time (minutes)* (Emergency Dept. has no average time component)	10 new 15 office cons. 20 hosp cons.	20 new 30 office cons. 40 hosp cons.	30 new 40 office cons. 55 hosp cons.	45 new 60 office cons. 80 hosp cons.	60 new 80 office cons. 110 hosp cons	5	10	15	25	40
Level	I	II	III	IV	V	I	II	III	IV	V

Continued on next page

Instructions:
Select level of service where the key components are met in the shaded area. Time and severity of condition are minor components. Do not average. If not all criteria are satisfied, select level where all requirements are met or exceeded.

Outpatient: New
Inpatient: Initial
Consults
ER
] 3 of 3 key components within the shaded area

Outpatient Established:
Inpatient: Subsequent inpatient/FU consult
] 2 of 3 key components within the shaded area

Counseling/coordination of care: Document referring to any of these key items: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction, or coordination of care.

**Time:* When greater than 1/2 of the encounter time is spent counseling/coordinating care, then time becomes the determinant. Time in office setting is face-to-face time. Time in inpatient setting is unit/floor time.

Definition of Terms

History
The levels of E/M services recognize four types of history defined as follows:
Problem focused Chief complaint; brief history of present illness of problem.
Expanded problem focused Chief complaint; brief history of present illness; problem pertinent system review.
Detailed Chief complaint; extended history of present illness; extended system review; pertinent past, family and/or social history.
Comprehensive Chief complaint; extended history of present illness; complete system review; complete past, family and social history.

Physical examination
The levels of E/M services recognize four types of examination defined as follows:
Problem focused An examination that is limited to the affected body area or organ system.
Expanded problem focused An examination of the affected body area or organ system and other symptomatic or related organ systems.
Detailed An extended examination of the affected body area(s) and other symptomatic or related organ system(s).
Comprehensive A complete single-system specialty examination or a complete multi-system examination.

Complexity of medical decision
Complexity of medical decision depends on the number of dx or tx options, the amount or complexity of data that must be analyzed, the risk of significant complications, morbidity, mortality, as well as the presence of co-morbidities. These may represent acute or chronic disease processes.
Straightforward Minimal dx or tx options; minimal or no data to review; and minimal risk of complication or morbidity.
Low complexity Limited dx or tx options; limited data to review; and low risk of complication or morbidity.
Moderate complexity Multiple dx or tx options; moderate data to review; or moderate risk of complications, morbidity, mortality, or the presence of significant comorbidities.
High complexity Extensive dx or tx options; extensive data to review; or significant risk of complications, morbidity, mortality, or the presence of significant comorbidities.

Type of encounter
New: The patient who has not received professional services from the physician within the last 3 years. (Medicare varies from CPT definition.)
Established: The patient who has received professional services from the physician within the last 3 years.
Consult: The rendering of opinion or advice regarding evaluation and/or management of a specific problem when requested by another physician or other appropriate source. Consultant may initiate diagnostic or therapeutic services. If the consultant subsequently assumes responsibility for management of a portion or all of the patient's condition(s), the consultation codes should not be used.
Confirmatory consult: (New or established) An opinion is requested (or required) on the necessity of appropriateness of a previously recommended medical treatment or surgical procedure.

For inpatient hospital services and follow-up inpatient consultations.

Inpatient	Initial			Subsequent Inpatient/Followup Consult		
History	Comprehensive	Comprehensive	Comprehensive	Problem focused interval	Expanded problem focused interval	Detailed interval
Physical exam	Comprehensive	Comprehensive	Comprehensive	Problem focused	Expanded problem focused	Detailed
Complexity of decision	Straightforward/ low	Moderate	High	Straightforward/ low	Moderate	High
Severity of condition	Low	Moderate	High	Stable/recovering/ improving	Inadequate response/ minor complication	Unstable/significant complication/significant new problem
Average time (minutes)*	30	50	70	15 subsequent 10 followup consult	20 subsequent 20 followup consult	35 subsequent 30 followup consult
Level	I	II	III	I	II	III

As the instructions above indicate, for some services you must have all three of the three components met of a certain level or else the correct level falls to the level before. For other services it is only necessary to have two of the three components met.

New patients, consultations, ER and initial inpatients require three of the three components to be met or the service drops one level. Specifically, these include: office visits, new patient; inpatient hospital care; office, initial inpatient and confirmatory consultations; emergency department services; comprehensive nursing facility assessments; domiciliary care, new patient; and home

Continued on next page

Continued from prededing page
visits, new patient. Established outpatient or follow-up inpatient visits must meet two of the three components. Specifically, these include: office visits, established patient; subsequent hospital care; follow-up inpatient consultations; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.

The examples below will further help illustrate the use of the grids.

Example I

A physician performs an office visit on a new patient, and meets the criteria of a comprehensive history, a detailed physical examination and a straightforward complexity of medical decision-making. The office visit would meet the criteria of level II on the chart or code 99202. This visit was for a new patient and three of the three components for this level of service were met, only for level II even though it entailed a comprehensive history and detailed physical examination which exceed the level II requirement. It remains at level II having met three of the three components for that level. The grid below illustrates the example.

Outpatient/Consult/ER	New/Consults/ER					Established				
History	Problem focused	Expanded problem focused	Detailed ER: Exp. prob.foc.	Compre-hensive ER:Detailed	Compre-hensive	*Minimal problem that may*	Problem focused	Expanded problem focused	Detailed	Compre-hensive
Physical examination	Problem focused	Expanded problem focused	Detailed ER:Exp. prob.foc.	Compre-hensive ER:Detailed	Compre-hensive	*not require presence*	Problem focused	Expanded problem focused	Detailed	Compre-hensive
Complexity of medical decision	Straight-forward	Straight-forward ER:Low	Low ER:Low to moderate	Moderate	High	*of physician*	Straight-forward	Low	Moderate	High
Severity of condition	Self-limited/ minor	Low to moderate	Moderate	Moderate to high ER:High	Moderate to high ER:High	Minimal	Self-limited/ minor	Low to moderate	Moderate to high	Moderate to high
Average time (minutes)* (Emergency Dept. has no average time component)	10 new 15 office cons. 20 hosp cons.	20 new 30 office cons. 40 hosp cons.	30 new 40 office cons. 55 hosp cons.	45 new 60 office cons. 80 hosp cons.	60 new 80 office cons. 110 hosp cons.	5	10	15	25	40
Level	I	II	III	IV	V	I	II	III	IV	V

Example II

If a physician performs a follow-up inpatient consultation and meets the criteria of a problem focused interval history, an expanded problem focused examination and a high complexity of medical decision-making, the physician would meet the criteria of level II on the chart or code 99262. Two of the three components were met for this level, even though the history involved a level I problem focused interval history, and the medical decision-making was of high complexity. The grid on the following page illustrates the example.

When to begin using the new codes

The new 1992 CPT-4 visit codes were effective Jan 1, 1992. Medicare claims for physician services provided through Dec 31, 1991, will be processed according to CPT codes and Medicare policies in effect when the services were provided. Even though the actual claim may not be submitted until after the start of the RBRVS on Jan 1, 1992, it cannot be processed under the RBRVS policies or new CPT codes. Medicare carriers will be required to process claims under both systems, according to the date services are provided.

To allow physicians time to become acquainted with the new codes, HCFA has established a 1-month grace period. For dates of service between Jan 1 through Jan 31, Medicare will accept and pay all claims with 1991 visit codes at the 1991 payment amount. Medicare will deny claims with 1991 visit codes with dates of service on or after Feb 1. January claims using the old visit codes must be filed by March 31. After that date, for claims with dates of services Jan 1 through Jan 31, Medicare will deny assigned claims, and for unassigned claims, Medicare will contact the physician to obtain the correct visit code.

Inpatient	Initial			Subsequent Inpatient/Followup Consult		
History	Comprehensive	Comprehensive	Comprehensive	Problem focused interval	Expanded problem focused interval	Detailed interval
Physical exam	Comprehensive	Comprehensive	Comprehensive	Problem focused	Expanded problem focused	Detailed
Complexity of decision	Straightforward/ low	Moderate	High	Straightforward/ low	Moderate	High
Severity of condition	Low	Moderate	High	Stable/recovering/ improving	Inadequate response/ minor complication	Unstable/significant complication/significant new problem
Average time (minutes)*	30	50	70	15 subsequent 10 followup consult	20 subsequent 20 followup consult	35 subsequent 30 followup consult
Level	I	II	III	I	II	III

For patients hospitalized in 1991 but not discharged until 1992, you have two options for claims submission. First, you can submit both the 1991 and 1992 visits on one claim form using the old visit codes (assuming the patient is discharged in January 1992). The entire claim will be processed using 1991 payment amounts and guidelines. Second, you may choose to submit a separate claim for the 1991 visits using the old visit codes and another claim for the 1992 visits using the new visit codes. Both would be processed under the appropriate payment amounts and guidelines. If a patient's 1991 hospitalization extends into 1992 beyond January, you must use the new codes for services provided after Jan 31, 1992.

Wisconsin's Medical Assistance Program (WMAP) will be ready to accept the new CPT evaluation and management codes as of Jan 1, 1992 and will have all of the new CPT physician codes on file by Jan 6. For dates of service on and after Jan 1, 1992, the WMAP will accept claims with either the new or old codes until March 31, 1992. Claims for 1992 dates of service received by EDS after March 31, 1992 must be submitted with the new CPT codes. Claims for dates of service 3/1/91 - 12/31/91 must still be submitted with the 1991 CPT codes.

The SMS and WMGMA have been working cooperatively to ensure that Wisconsin's private insurers will accept the new codes as of Jan 1. Most of the large private insurers have indicated that they will be ready. We continue to work with the smaller carriers to assist them in their preparations, including the offering of a seminar designed specifically for private insurers.

Other changes influencing codes

The new CPT-4 book describes and defines the following categories differently:

New and established patients. The AMA redefined the "new" or "established" patient classifications in the CPT-4 system. A "new" patient is one who has not received any professional services from the physician within the past 3 years. Medicare has limited the "new" patient definition to those patients who have not received any professional services from any physician in the same practice, regardless of specialty, for 3 years. An "established" patient is one who has received professional services from the physician(from any physician in the same practice, regardless of specialty for Medicare), within the past 3 years.

The CPT-4 instructs that patients seen by on-call physicians should, regardless of specialty, be classified the same as they would be by the physician who was not available. Hospital inpatient, emergency room, and nursing facility visits do not distinguish between "new" and "established" patients.

Critical care. Critical care codes have the same definitions as in 1991 CPT-4, but the physician must be in constant attendance to use them. The code for the first hour of critical care (99291) should be used only once per day even if the time spent by the physician is not continuous on the day. Additional critical care should be reported in half-hour increments, using the second critical care code 99292. To bill for a half-hour increment of critical care to Medicare, the physician must spend 15 to 30 minutes of time with the patient in addition to the full hour of critical care.

Follow-up critical care codes have been deleted. Follow-up care that does not require constant physician attendance will be coded as subsequent inpatient hospital visits.

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Prolonged evaluation and management. 1992 CPT-4 provides a new modifier to be used with E/M codes: 21, prolonged evaluation and management services. This modifier should be used to report services that are unduly prolonged, or with the highest level of E/M service within a given category when the service provided exceeds the highest level provided in the category.

Medicare considers this an "information only" modifier and it will not increase reimbursement. Medicare also has stated that it should not be used to describe difficulty in obtaining a history or physical examination due to the presence of cognitive, physical or ADL impairments or advanced age.

CPT-4 book format changes

The CPT-4 definitions necessary to understand the new codes, as well as the other new terms incorporated into the system, are found in the Introduction and Guidelines Sections of the 1992 CPT-4 book. Additionally, a pamphlet entitled, "New Evaluation and Management CPT Codes," was sent with a WPS-Medicare mailing in mid-November. This pamphlet, written by the AMA, contains valuable examples on use of the new codes.

In the 1992 CPT-4 book, the 90000 section has been divided into two sections. The E/M codes will be located in the front of the book, and the rest of the codes, the medicine codes, are relocated to the back of the CPT-4 book. Case management codes in 1992 CPT-4 will have the current definitions, except for 98900 and 98902 for medical conferences with patients or family, which have been deleted. The other case management codes have been retained but are renumbered and will be located in the last section of the book. Medicare does not reimburse for case management codes because these services are considered part of the visit.[15,16]

Other policies effective January 1

The concept of a "global" fee for surgical procedures is not new. Under the RBRVS payment system, however, new policies are being established which will create a uniform national definition for "global surgery." The new policies will ensure that, nationwide, payment will reflect the same amount of work and resources involved in providing the specific service.

The SMS recognizes that physicians have many questions and concerns about the surgical policies. Most of the questions relate to the procedures that will be used in situations where more than one physician provides services included in the global package. Some of the questions are: 1) What if I am not the performing surgeon, yet I provide post-operative inpatient care? 2) If I am in a different locality from the surgeon, and am performing post-operative care, will my reimbursement be based on my own locality or the locality where the surgery was performed? 3) What if I am a non-participating physician sharing care with a surgeon who is participating. Will I be able to balance bill up to my limiting charge for that portion of the global package to which I am entitled? 4) If the surgeon fails to submit a claim using the appropriate modifier for less than global service, how can I file my claim for post-operative care and will I be paid? The SMS continues to work with WPS-Medicare for answers to these questions. Many are waiting on instructions to the local carriers from HCFA. Please continue to monitor *Medigram, Medicare Alert*, and *WMJ* for updates, as well as WPS-Medicare's newsletter *Communique*.

What follows is a review of what is known regarding the RBRVS payment system for global surgery and other RBRVS surgical policies.

Major surgery

The global surgery package for major surgery includes:

- all visits, in or out of the hospital, performed the day before the surgery are considered pre-operative (HCFA has stated explicitly that it will carefully monitor services prior to surgery to detect abuses);
- all services that are a usual and necessary part of a surgical procedure are considered intra-operative services; and
- all services related to normal recovery for 90 days after the surgery, not including services unrelated to the surgical diagnosis or an added course of treatment, constitute a post-operative period.

The global surgery fee includes all additional medical or surgical services due to complications of the procedure. Surgically necessary return trips to the operating room, for any reason and without regard to "fault," can be billed separately from the global surgery fee, and will be reimbursed at a reduced rate. (See modifiers 78 and 79 below.)

The global surgery fee encompasses these services: dressing changes, local incisional care, and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal or urinary catheters, routine peripheral intravenous lines, routine nasogastric and rectal tubes; and change and removal of tracheostomy tubes. Other types of services included are fluid and wound management, anticoagulation for thrombophlebitis and discharge planning.

Whether performed by the surgeon or another physician some services are excluded from the global package and can

be billed separately. Examples include: the initial consultation/evaluation, visits unrelated to the diagnosis for which the surgical procedure is performed, clearly distinct surgical procedures during the post-operative period of the original surgery which are not reoperations or treatment for complications (See new modifier 79 below) treatment for an underlying condition, diagnostic tests and procedures, post-operative complications that require return visits to the operating room, immunosuppressive therapy and certain supplies (See section regarding supplies on page 41).

Additional detail is given in the WPS-Medicare policy on global surgery for major surgical procedures.

Minor surgery and Non-incisional procedures

In addition to major global surgeries, RBRVS makes separate provision for minor surgeries and non-incisional procedures. These include "starred" procedures in the surgery section of CPT, and diagnostic and therapeutic endoscopies. WPS-Medicare published a list of these procedures in the December *Communique*. These minor surgeries and non-incisional procedures are subject to the following restrictions:

- Visits on the same day as the minor surgery or endoscopy. If a visit is required, and is documented as a separate identifiable service, it may be billed separately. This visit must be identified by modifier 25. (See modifier 25 below.)
- Services related to the post-operative recovery from the procedure. Minor surgeries will have a post-operative period of either zero or 10 days during which no charges related to the recovery may be made. Services for treatment of the underlying condition may be charged.

There is no post-operative period for endoscopy procedures performed through an existing body orifice. Procedures requiring an incision will be subject to the appropriate major or minor surgical policy.

New modifiers

Four new modifiers have been developed by the CPT Editorial Panel to identify a service or procedure furnished during a global period that is not normally part of the global surgery fee. The modifiers are:

24 This modifier will be used by the physician who is providing post-operative care services for an evaluation and management service unrelated to the original procedure. Use of this modifier will require the submission of documentation with the claim until HCFA has fully analyzed how frequently the modifier is used.

79 This modifier will be used by the physician who is providing post-operative care services, for a procedure or service, other than an evaluation and management service, which is unrelated to the original surgical procedure. This modifier should also be used for staged procedures (eg, burn debridement). A new 90-day post-operative period will begin after each procedure.

25 This modifier will be used by the physician performing the procedure for a separately identifiable evaluation and management service on the same day as the procedure. It must be unrelated to the usual pre- and post-operative care associated with the procedure. No documentation is required with this modifier.

78 This modifier will be used when a return trip to the operating room for a related procedure is required during the post-operative period. The payment level for re-operations is set at the value of only the intra-operative portion of the global package for the CPT code (procedure) performed. If no CPT code exists for the service, the payment level may not exceed 50% of the value of the intra-operative service originally performed. A new 90-day post-operative period will begin following return trips to the operating room.

The new modifiers are intended to facilitate claims processing by identifying which services should be paid and which should not be paid. In using these modifiers, the physician is verifying that the criteria have been met. The Medicare carriers processing claims may request additional documentation from physicians or initiate audits of physicians where use of the modifiers appears to be unusually high. Services billed using the new modifiers must be medically necessary.

Modifier 75 is no longer needed because computer systems can identify concurrent claims. It has,therefore, been deleted from CPT-4.

Multiple surgery

Under RBRVS, reimbursement for multiple procedures performed by the same surgeon (CPT modifier 51) on the same patient on the same day will be based on the global fee for each of the procedures. Reimbursement will be reduced as follows: 100% of the global fee for the highest valued procedure; 50% of the global fee for the second most expensive procedure; and 25% of the global fee for the third, fourth, and fifth procedures. This reduction does not apply to procedures which are defined by CPT as additional procedures because the reduction is incorporated into the code.

If more than five procedures are performed, each additional procedure beyond the fifth will require submission of documentation. The Medicare carrier will review the documentation and determine the payment amount.

The multiple surgery rules will not apply to dermatology services identified by CPT codes which represent that multiple surgical procedures have been performed. For dermatology services which are not represented as multiple surgical procedures by the CPT code, a 50% reduction in the value will be applied to the second procedure. A physician may submit a "by report" bill when three or more lesions are removed.

In the case of multiple endoscopic procedures, HCFA has developed a special formula for calculating reimburse-

Continued on page 37

ONLY ONE H_2-ANTAGONIST HEALS REFLUX ESOPHAGITIS AT DUODENAL ULCER DOSAGE. ONLY ONE.

Of all the H_2-receptor antagonists, only Axid heals and relieves reflux esophagitis at its standard duodenal ulcer dosage. Axid, **150** mg b.i.d., relieves heartburn in **86%** of patients after one day and **93%** after one week.[1]

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Brief Summary. Consult the package insert for complete prescribing information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

PV 2093 AMP [101591]

Additional information available to the profession on request.

Lilly

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Indianapolis, Indiana
46285

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Continued from page 35

ment. It is expected that more information will be provided in the near future regarding the claim filing requirements and specific reimbursement for the multiple endoscopic procedures.

Bilateral surgery

When a procedure normally done on only one side of the body is performed on both sides of the body, the bilateral modifier (50) should be used. The modifier is not necessary for procedures which are typically bilateral in nature since the appropriate CPT code will identify this. Medicare will approve 150% of the global fee for bilateral procedures.

Less than global service

In some circumstances, more than one physician could furnish services which are considered part of the global surgery package. In these situations, Medicare will pay each physician directly for the portion of the global surgery service furnished to the patient. The amount paid in total to the physicians will equal the amount which would have been paid if only one physician had furnished all of the services in the global package. HCFA has divided the global package into three separate payment segments and assigned percentages to each segment. The three segments are pre-op, intra-op, and post-op. The intra-operative segment includes both the intra-operative and the inpatient post-surgery services. The post-operative segment includes only the post discharge care in the office.

In the case where the surgeon performs only the procedure and does not perform the inpatient and office post-operative care, the 54 modifier must be used with the surgical procedure code. The physician performing the inpatient and office post-operative care should use the surgical CPT code with the 55 modifier. There is no mechanism for reimbursement of inpatient post-op care when provided by a physician other than the surgeon. HCFA is researching this issue.

The pre-op segment of the global surgery package cannot be billed separately.

When different physicians in a group practice (billing under a clinic provider number) participate in the care of the patient, the group bills for the entire global package. The physician who performs the surgery is the one who bills for the global surgery. The exception to this is when a new physician furnishes the office post-operative care, the group must bill for the pre- and intra-operative care and the post-operative care as separate line items using the appropriate modifiers (54,55).

Assistants-at-surgery

The payment level for physicians who assist at surgery (modifiers 80, 81, 82) is set at the lower of the actual charge, or 16% of the fee schedule amount for the global surgical service. Services are covered when the assistant to the primary surgeon is considered medically necessary and appropriate. Considered is the need for the expertise of another surgeon in a complicated case for decision-making or for surgical involvement. Medicare has identified procedures for which an assistant-at-surgery is prohibited based on practice norms or medical necessity. These procedures are listed in the 1991-1992 Medicare Part B Reference Manual, available from SMS (See Resource directory on page 14). Physicians are prohibited from billing Medicare or the patient for assistant-at-surgery services for these procedures.

No payment will be made for an assistant-at-surgery where co-surgeons perform the procedure.

Co-surgeons and surgical teams

The skills of two surgeons are required to perform some surgical procedures. A list of surgeries in which co-surgeons will be approved by Medicare has been developed nationally. This listing will be available through WPS-Medicare. Procedures which do not usually require co-surgeons must include documentation to substantiate the need for co-surgeons. Until the listing of Medicare approved co-surgeries is published, all claims involving co-surgeons must include documentation.

Each of the co-surgeons should bill Medicare using the surgical CPT code with the 62 modifier and the full appropriate

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fee as if the surgeon performed the service alone.

Payment for each surgeon will be based on half of the approved amount. The approved amount can not exceed 125% of the global fee.

Payment amounts for team surgeries (modifier 66) have historically been determined by the local Medicare carriers and are considered necessary only in unusual circumstances. This will not change under the RBRVS program.

Each surgeon should bill Medicare using the surgical CPT code with the 66 modifier and the full appropriate fee as if the surgeon performed the service alone. Documentation indicating that a team was medically necessary and the level of care provided in the post-operative period must be submitted with the claim.

Multiple different surgical procedures, performed by surgeons of different expertise, should be submitted using the 22 modifier. Each surgeon should report the procedure performed. Reimbursement for these procedures will be determined on a case-by-case basis by the Medicare carriers.

Again, the SMS recognizes that this review leaves many questions regarding global surgery and other RBRVS surgical policies unanswered. Please continue to monitor *Medigram, Medicare Alert*, and *WMJ* for updates, as well as WPS-Medicare's newsletter *Communique*. Physicians will be held accountable to the information presented in *Communique*.[15,16]

Questions?

Call the
State Medical Society
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St. Luke's Healthcare Association – a progressive, multifacility healthcare system located in Saginaw, Michigan – currently has private practice and hospital career opportunities for physicians in selected areas of specialization.

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Payments change for interpretation of EKGs

SEPARATE PAYMENT will not be made for interpretation of electrocardiograms performed as part of, or in conjunction with, a visit or consultation for the following CPT codes: 93000, 93010, 93040, and 93042. The RBRVS values for office visits, office consultations, emergency visits, hospital consultations and visits, critical care services, nursing home visits, home visits, and nursing facility codes were increased to reflect the resources used for EKG interpretations. Therefore, reimbursement for the interpretation is included in payment for these services. Physicians interpreting EKGs who do not see the patient will not be reimbursed by Medicare for the service.

Payment will continue to be made separately for the interpretation of specialized EKGs under the following CPT codes: 93201, 93204, 93205, 93209, 93220, 93222, 93227, 93230, 93235, and 93237. The technical component for EKGs will be paid separately. Claims for the technical component only, when not indicated by the CPT code, should be submitted using the "TC" modifier.

The SMS has been reviewing the issue of what contractual arrangements could be established to provide payment for physicians who routinely interpret EKGs, but do not see the patient. The situation is complicated by the variety of current arrangements between hospitals and physicians reading EKGs, and between primary care physicians who regularly seek the interpretation services of specialists. The two primary contractual options include: 1) the hospital contracting directly with physicians for interpretations; and 2) physicians contracting with other physicians for interpretations. Both of these arrangements are appropriate. Concerns have been raised about the second option as to whether it constitutes fee-splitting or illegal remuneration under the Social Security Act. It is SMS legal counsel's opinion that if an EKG professional reading contractual service is performed, and reimbursement is made on a reasonable charge basis for that service, such a contractual arrangement would not be illegal. The SMS is in the process of developing a sample model contract which could be used as a guide for use by physicians who are in category 2.

UPINs required January 1

UNIQUE PHYSICIAN identification numbers (UPIN) were mandatory for claims submitted as of Jan 1, 1992. A recent WPS-Medicare sampling of claims determined that only 3-4% of claims, which will require UPINs, currently contain the necessary information. If you practice one of the specialties listed below or if you bill for any of the consultation codes listed below, the name and number of the referring or the ordering physician must be entered on the HCFA 1500. For the HCFA 1500 (1-84), the name of the referring or ordering physician and the UPIN must be entered in box 19. For the HCFA 1500 (12-90), the name must be entered in box 17 and the UPIN in box 17a.

The following specialties are required to submit UPINs: 21 pathologic anatomy; clinical pathology (osteopaths only); 22 pathology; 25 physical medicine and rehabilitation; 30 radiology; 31 roentgenology, radiology (osteopaths only); 32 radiation therapy (osteopaths only); 36 nuclear medicine; 51 medical supply company with C.O. (certified orthotist) certification; 52 medical supply company with C.P. (certified prosthetist) certification; 53 medical supply company with C.P.O. (certified prosthetist-orthotist) certification; 54 medical supply company (not included in specialties 51, 52 or 53); 55 individual certified orthotist; 56 individual certified prosthetist; 57 individual certified prosthetist-orthotist; 58 individuals (not included in specialties 55, 56 or 57); 63 portable x-ray supplies (billing independently); 69 independent laboratory (billing independently); and 87 all others,

Type of service codes no longer required

THE TYPE OF SERVICE CODE is no longer required on Medicare claims. The type of service will now be determine based on the new place of service codes and the procedure code you submit on your claim.

As in the past, some procedure codes will not accurately reflect the service you provide and you will need to use a modifier with the procedure code. For example, at times you may need to use the 26 modifier to indicate you performed the professional component of a service only or the TC modifier to indicate you performed the technical component of a service only.

eg drug and department stores.

The following consultation codes, regardless of specialty, are required to submit UPINs: 90600-90654 (99241-99275 in 1992); 80500-80502; 88325; and 76140.

The following exceptions do not require UPINs: all inpatient hospital services; screening mammography code 76092; and screening Pap smear codes Q0060 and Q0061 (P3000 and P3001 in 1992).

In cases where there is no referring or ordering physician and you are subject to the criteria above, list either the physician's name and UPIN of the physician providing the service or enter "self" or "none" in the boxes of the HCFA 1500 described above.

Obtaining UPINs

UPIN directories are available through WPS-Medicare. To obtain a free copy (one per provider number), write to: WPS-Medicare Part B, Attn: Customer Service, PO Box 1787, Madison, WI 53701. Additional directories ($15 each) can be ordered by writing to: Government Printing Office, Room 3836, Building 3, Washington, DC 20401.

If a physician is not listed in the directory and does not know his or her UPIN, numbers can be requested through WPS-Medicare Customer Service at (608) 221-3218.[150th]

Place of service code changes

As part of HCFA's standardization initiative to accommodate physician payment reform, there have been some changes in the way that place of service codes are identified and defined.

The new place of service codes are given in the December issue of Medicare's newsletter, *Communique*. A crosswalk from the old to the new place of service codes is below. You should begin using the new codes Jan 1, 1992, whether the date of service is in 1991 or 1992:

New code		Old code
00-09	Unassigned	
11	Office	3 - (0)
12	Home	4 - (H)
10, 13-19	Unassigned	
21	Inpatient hospital	1 - (IH)
22	Outpatient hospital	2 - (OH)
23	Emergency room, hospital	2 - (OH)
24	Ambulatory surgical center	B - (ASC)
25	Birthing center	O - (OL)
26	Military treatment facility	O - (OL)
27-29	Unassigned	
31	Skilled nursing facility	8 - (SNF)
32	Nursing facility	7 - (NH)
33	Custodial care facility	O - (OL)
34	Hospice	O - (OL)
30, 35-39	Unassigned	
41	Ambulance, land	9
42	Ambulance, air or water	9
40, 43-49	Unassigned	
51	Inpatient psychiatric facility	O - (OL)
52	Psychiatric facility partial hospitalization	5 or 6
53	Community mental health center	5 or 6
54	Intermediate care facility, mentally retarded	D - (STF)
55	Residential substance abuse treatment facility	C - (RTC)
56	Psychiatric residential treatment center	C - (RTC)
50, 57-59	Unassigned	
61	Comprehensive inpatient rehabilitation facility	O - (OL)
62	Comprehensive outpatient rehabilitation facility	E - (COR)
65	End stage renal disease treatment facility	F - (KDC)
60, 63, 64	Unassigned	
66-69	Unassigned	
71	State or local public health clinic	O - (OL)
72	Rural health clinic	O - (OL)
70, 73-79	Unassigned	
81	Independent laboratory	A - (IL)
80, 82-89	Unassigned	
99	Other unlisted facility	O - (OL)
90-98	Unassigned	

[150th]

Payment for supplies detailed

Medicare will reimburse separately for some supplies including: splints and casting supplies; surgical dressings; durable medical equipment–HCPCS E codes; and orthotics and prosthetics–products described under the HCPCS L codes, urinary L codes, urinary catheters and related products for permanent incontinence.

Additionally, Medicare will reimburse separately for surgical trays used for the following procedures when done in a physician's office. To bill for supplies used with the following procedures, use code A4550.

HCPCS*	Description
19101	Biopsy of breast
19120	Removal of breast lesion
20200	Muscle biopsy
20205	Deep muscle biopsy
20220	Bone biopsy, trocar/needle
20225	Bone biopsy, trocar/needle
20240	Bone biopsy, excisional
25111	Remove wrist tendon lesion
28290	Correction of bunion
28292	Correction of bunion
28293	Correction of bunion
28294	Correction of bunion
28296	Correction of bunion
28297	Correction of bunion
28298	Correction of bunion
28299	Correction of bunion
32000	Drainage of chest
37609	Temporal artery procedure
38500	Biopsy/removal, lymph node(s)
43200	Esophagus endoscopy
43202	Esophagus endoscopy, biopsy
43220	Esophagus endoscopy, dilation
43226	Esophagus endoscopy, dilation
43234	Upper GI endoscopy, examination
43235	Upper GI endoscopy, diagnosis
43239	Upper GI endoscopy, biopsy
43245	Operative upper GI endoscopy
43247	Operative upper GI endoscopy
43251	Operative upper GI endoscopy
45378	Diagnostic colonoscopy
45379	Colonoscopy
45380	Colonoscopy and biopsy
45382	Colonoscopy, control bleeding
45383	Colonoscopy, lesion removal
45385	Colonoscopy, lesion removal
49080	Puncture, peritoneal cavity
57520	Biopsy of cervix
58120	Dilation and curettage
62270	Spinal fluid tap, diagnostic
85095	Bone marrow aspiration
85102	Bone marrow biopsy
96440	Chemotherapy, intracavitary
96445	Chemotherapy, intracavitary
96450	Chemotherapy, into CNS

* All CPT codes and descriptors, copyright 1991 AMA.[15pt]

CMN forms require physician completion

Under OBRA '90 requirements, physicians are required to complete the medical portion of the Certificate of Medical Necessity (CMN) form for durable medical equipment (DME). Physicians cannot charge for this service. DME suppliers may not distribute to physicians or Medicare beneficiaries any completed or partially completed forms or other documents to be submitted to Medicare for verification of medical necessity. Any supplier who knowingly and willfully violates this provision is subject to a civil monetary penalty up to $1,000 for each form or document. HCFA has developed a phase-in for implementation of the CMN forms which began Dec 1, 1991. For services furnished on or after Dec 1, claims for only the following services will be denied if the physician does not fill out the appropriate portions of the CMN form for DME: TENS, power operated vehicles, air fluidized beds, decubitus care pads (egg crates, foam, etc), and seat lift mechanisms.[15pt]

New HCFA 1500 claim form instructions

Instructions for completing the revised HCFA 1500 (12-90) claim form are final and were published in the December issue of Medicare's newletter, *Communique*. WPS is accepting the form now and it will be mandatory May 1, 1992. (The initial April 1 deadline has been pushed back to May.) The SMS has the new claim form available for purchase. For more information, call Bill Guerten at the SMS: (608) 257-6781 or (800) 362-9080.[15pt]

Budget cuts affect Medicare claims review

Post-payment review

The post-payment review process is a retrospective evaluation of services provided and billed for under the Medicare program. It involves monitoring of claims to determine practice norms, identification of providers who differ from the norms, determination and correction of identified problems, and education and monitoring of providers to ensure that the problems are resolved. Corrective action may include collection of overpayment or further professional education. Prepayment reviews of a provider's claims can be imposed for severe or long-standing problems. All providers who have been identified in prior reviews as needing corrective action are subject to further audits of their claims.

Severe budget cuts to the Medicare carriers in 1992 will affect the prepayment review of claims as they pass through the initial claims processing system. WPS-Medicare is anticipating that fewer claims will be held for research or "development" prior to payment being made. This means that there may not be as many denials as in the past. WPS-Medicare expects, however, to enhance its efforts in auditing physicians after claims are processed. Collection of overpayment will take place if the claim has been paid inappropriately.

WPS-Medicare will be selecting a sample of claims containing the new evaluation and management (E/M) CPT-4 codes for visit and consultation services for post payment review in January 1992 and continuing through June 1992. It will request and review documentation submitted to determine whether the E/M codes have been used appropriately. If the documentation supports the level of service billed, letters will be sent to physicians thanking them for their assistance and confirming that the codes were used properly. If the documentation fails to support the level of service billed, physicians will be informed of the code that would have been appropriate according to the documentation that was submitted. These audits will be educational only and will not affect reimbursement.

Informal reviews

An informal review is a process which allows a provider to challenge claims processing decisions and offers the opportunity to submit additional information which may affect these decisions. Due to the cut in WPS-Medicare's budget, it is anticipated that informal reviews may take 6 months or longer to be processed. The budget cuts are being implemented at a point in time when the carrier's resources will already be strained by the demands of implementing the new RBRVS system. WPS-Medicare reports "There just won't be enough manpower to process the volume of reviews expected in 1992 in a timely manner."

To avoid the informal review and audit process, physicians and office staff should keep up to date on Medicare issues and claims submission guidelines and be sure claims are submitted properly the first time.[150th]

Extra care required with ICD-9 codes

Beginning with services provided Jan 1, 1992, claims may be denied by WPS-Medicare if the ICD-9 code listed is not specific enough (ie, taken out to the fourth or fifth digit). To avoid unnecessary denials, be sure that the most specific diagnosis code available is listed on the claim. WPS-Medicare has provided information on ICD-9 coding in the following issues of *Communique*: February 1989, March 1989, October 1989, February 1991. Also see the "Resource directory" on pages 14 and 17 for information on ordering ICD-9 books and for seminars on ICD-9 coding.[150th]

Public health

Project FACE: Wisconsin surveillance of fatal occupational injuries

Lawrence P. Hanrahan, MS; Dee Higgins, RN; Linda Haskins; and Henry Anderson, MD, Madison

In October 1987, a 24-year-old plumber died when he fell 22 feet through a skylight opening to a concrete floor.[1] In the summer of 1988, a 19-year-old laborer was electrocuted when a metal work platform on which he was standing penetrated the covering of an overhead crane's 440-volt contact conductor and became energized.[2]

Also that summer, a 25-year-old electroplater died after entering a metal plating vat he was cleaning. Four co-workers also died when they entered the vat in rescue attempts.[3]

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These are classic examples of occupational fatalities that happen far too often in the United States. In each of the fatalities cited, state and federal investigators were able to discover and recommend effective countermeasures to prevent similar incidents.[1-3] Occupational fatalities are preventable.

Estimates of the number of work-related deaths occurring in the United States vary widely because there is a lack of national data suitable for studying occupational injury and fatalities.[4,5] The Bureau of Labor Statistics estimated that 3,740 occupational fatalities occurred in 1984.[6] In contrast, the National Safety Council estimated that 11,300 occupational fatalities occurred in the same year.[6] The National Traumatic Occupation Fatality database indicates nearly 7,000 work-related deaths occurred annually from 1980 through 1985.[7] These fatality estimates differ because definitions and ascertainment methods used by each source may differ, and because of problems in case recognition and accurate reporting.[4,5] For example, in a recent unpublished study of 1988 occupational fatalities in Wisconsin, 118 cases were recorded in the Wisconsin Workers Compensation Case History file, while 108 cases were recorded in the Wisconsin Death Certificate file. Only 44% (52 cases) were correctly logged into both systems.

For certain industries and work places,

Continued on next page

Wisconsin traumatic occupational fatalities, 1981-1987, by cause of death and gender.

		Males		Females		Total	
E-code	**External cause of death**	*Deaths*	*%*	*Deaths*	*%*	*Deaths*	*%*
810-819	motor vehicle traffic accidents	160	24	10	29	170	24
880-888	accidental falls	75	11	2	6	77	11
910-915	suffocations & asphyxiations	31	5	2	6	33	5
919.0	agricultural machines	113	17	7	21	120	17
916-918 & 919.1-928	other accidents	194	29	5	15	199	28
	all other E-codes	93	14	8	24	101	14
	totals	666	100	34	100	700	100

Continued from preceding page
case reporting represents additional problems. For example, fatalities in offshore fishing, certain fatalities on the farm, and work-related deaths in one-person shops may not be captured by these reporting systems and recognized as an occupational fatality.

Background

We reviewed death certificates from 1981 through 1987 to determine the effect of traumatic occupational fatalities in Wisconsin. Cases were obtained by selecting deaths occurring from 1981 through 1987 for individuals aged 16 years or older, an external cause of death (E code series E 800 through E 999), and the death certificate designating that the place of occurrence was "at-work."

During the period, 700 deaths of this type occurred. Wisconsin annually has between 86 and 120 traumatic occupational fatalities. Working Wisconsin males have a fatality rate of 7.9 per 100,000 workers, while females have a rate of 0.5 per 100,000. Traumatic deaths from agricultural machines accounted for 17% of the deaths, while fatalities involving motor vehicles accounted for 24%. Falls represented 11% of the cases (Table).

Several high-risk industries were also identified for male workers, including logging (69/100,000), agriculture (29/100,000), trucking/warehousing (29/100,000), manufacturing not elsewhere classified (27/100,000), and construction (17/100,000) (Figure 1). That is, the logging industry had a relative risk (RR) or fatality rate that was 8.8 times greater than the all-industry average rate of 7.9/100,000. Similarly, the agricultural and trucking/warehousing industries both had relative risks of 3.7, manufacturing not elsewhere classified 3.5, saw mills 2.2, and construction 2.1.

When deaths were analyzed by occupation, a similar pattern of risk emerged (Figure 2). Forestry/fishing laborers had a fatality rate of 68/100,000 (RR: 8.6), farm operators and managers 39/100,000 (RR: 5.0), construction workers 36/100,000 (RR: 4.6), and motor vehicle operators 20/100,000 (RR: 2.6).

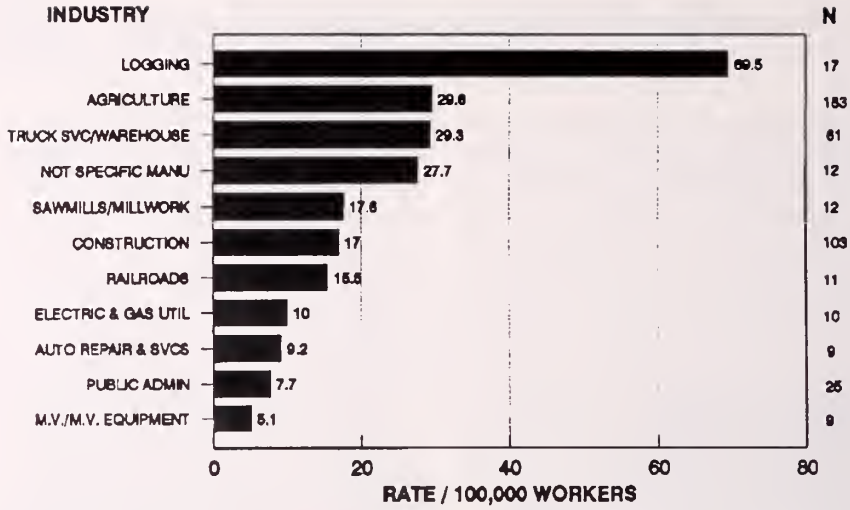

Fig 1.–Wisconsin traumatic occupational fatalities for males, 1981-1987; industry number of fatalities and incidence rate.

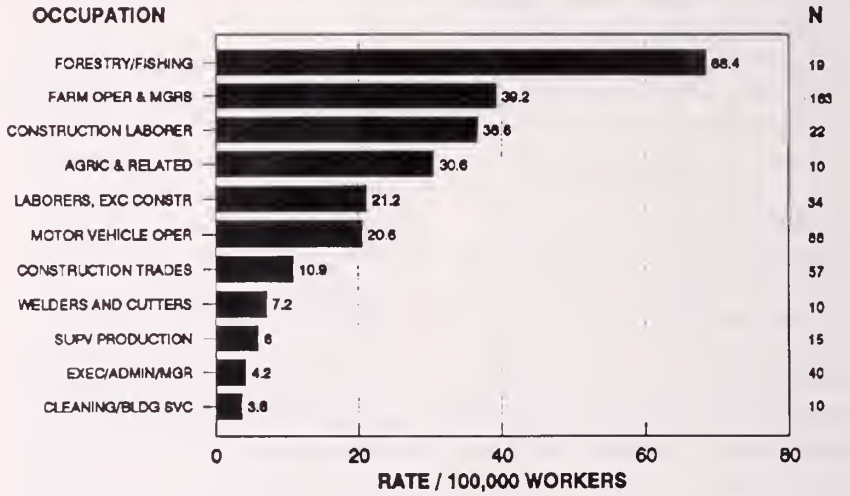

Fig 2.–Wisconsin traumatic occupational fatalities for males, 1981-1987; occupational number of fatalities and incidence rate.

The project

In October 1991, the Centers for Disease Control National Institute for Occupational Safety and Health (CDC-NIOSH) granted the Wisconsin Department of Health and Social Services a 5-year cooperative agreement grant to fund a traumatic occupational fatality surveillance and intervention program. The program, called the Fatal Accident Circumstances and Epidemiology (FACE) Project was initially established by CDC-NIOSH in 1982 to provide technical assistance and to develop information on additional causal factors for occupational fatalities.[5]

Currently there are 9 state-based projects. The goal of these surveillance, research and intervention programs is to "prevent fatal work injuries in the future by studying the working environment, the worker, the task the worker was performing, the tools the worker was using, the energy exchange resulting in fatal injury, and the role of management in controlling how these factors interact."[2,3]

The Wisconsin cooperative agreement has as its primary goal to effect a measurable reduction in traumatic occupational fatalities. This will be accomplished by strengthening the occupational public health infrastructure of Wisconsin. The resources of occupational safety and health epidemiologic research and public health prevention programs will be integrated at state and local levels. The objectives for the cooperative agreement include:

- developing a timely, comprehensive, multiple (inter-agency) source state-level surveillance system for identifying and recording basic epidemiologic data on all traumatic occupational fatalities occurring within the state;
- conducting investigations of selected traumatic occupational fatalities using the NIOSH FACE investigative model;
- identifying potential risk factors for selected types of traumatic occupational fatalities that will be useful for putting research efforts into priority and for targeting intervention strategies;
- developing intervention demonstration projects to reduce traumatic occupational injuries and fatalities; and
- developing and disseminating preventive recommendations to reduce the risk of fatal traumatic injuries within the state.

The CDC-NIOSH FACE Project currently has detailed epidemiologic investigation protocols for falls, electrocutions, and asphyxiation deaths caused by entry into confined spaces. Wisconsin FACE investigations will occur when these types of occupational fatalities happen. Additional epidemiologic investigation protocols will be developed jointly in the future with CDC-NIOSH.

Comment

Wisconsin has under its current Sentinel Event Notification System for Occupational Risks (SENSOR) Program an active inter-agency working group that addresses state occupational health problems.[8] Members of this prevention center include the Department of Health and Social Services, the Department of Industry, Labor, and Human Relations, the Occupational Safety and Health Administration, the University of Wisconsin (Department of Preventive Medicine, Department of Industrial Engineering, and UW Extension School for Workers), and the National Farm Medicine Center (Marshfield Medical Research Foundation).

The prevention center has established an inter-agency network of those who are collectively committed to occupational health problem solving. The primary focus of the center has been the surveillance and prevention of occupational diseases. Funding from this CDC-NIOSH FACE cooperative agreement will now help to focus some of these resources into the prevention of traumatic occupational fatalities.

The success of the Wisconsin FACE

Continued on next page

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surveillance program is dependent upon the timely receipt of thorough fatality reports. Medical examiners, and coroners can play a vital part in this effort when completing death certificates by: carefully listing the underlying and all contributing external causes of death; noting the occupation and industry of the deceased; and indicating that the fatality occurred "at work."

Acknowledgments
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Bushnell B. Cary, MD: The first president of the State Medical Society of Wisconsin

Earl R. Thayer and Thomas J. Wolfe, Madison

In 1855, the SMS published as part of the year's *proceedings* a "Preliminary History" of the Society. This, not surprisingly, was the first history of the SMS. Founded only 13 years previously, the Society was an organization struggling to maintain its existence, as indicated by the cancellation of several annual meetings for lack of a quorum. The history was an attempt to provide some impetus to the Society, to convince members that the organization possessed a useful past leading to a more beneficent future. Echoing the difficulties of the Society, however, the history suffered from the loss of all pre-1847 records.

One result of this absence was the eventual establishment of Mason C. Darling, MD, of Fond du Lac, as the first president of the Society. While the "Preliminary History" merely identified Darling as the incumbent in 1847, subsequent historians have assumed that Dr Darling held the office since the inception of the Society. Today, Dr Darling is first on the official list of past presidents. A memorial observance in Fond du Lac in 1966 honored him as such.

Businessman, state legislator, speaker of the House, speaker of the Council (Senate), and US representative, philanthropist, in addition to physician, Dr Darling was a sterling figure to have guided the Society during its difficult early years. Unfortunately, this impressive account is wrong.

An extensive search of the state's major newspapers, part of an on-going research project on the history of the Society (funded by the CES Foundation), has recovered the minutes of annual meetings held during those earliest years. From these accounts, two new figures emerge as Society presidents before Dr Darling: Bushnell B. Cary, MD, of Racine (1842-1845) and Jesse Moore, MD, of Beloit (1845-1846). A sketch of this early period serves not only to correct the record, but to reveal something of the times surrounding the founding of the Society.

Birth of the SMS

On Feb 19, 1841, Gov Henry Dodge signed into law Act 53 of the Legislature, authorizing the establishment of the Medical Society of the Territory of Wisconsin. The law designated 13 physicians as the incorporators of the Society. It was no surprise that Bushnell B. Cary, MD, headed the list.

Two years earlier, Dr Cary had suggested to the Racine County Medical Society that "the different medical societies" should meet in Madison to form a territorial association to promote the science of medicine.[1] His colleagues promptly elected him president of the county group and delegated him to rouse the doctors around the territory to such a meeting.

Dr Cary's use of the phrase "the different medical societies" piques the curiosity. Buck's *Pioneer History of Milwaukee* indicates a medical society being formed there in 1837. The substantial number of doctors in southwest Wisconsin and in Rock County hints at the possibility of societies in those areas, but that is mostly conjecture.

Dr Cary's medical education and practice in the East, where medical societies were popular among "regular" physicians, no doubt influenced his desire to see such a society in Wisconsin. Whether he ever called the proposed meeting in Madison is unknown, but he carried out the request of his Racine colleagues by presenting a resolution to the Assembly in early 1841. This quickly became a bill which took only 35 days from introduction to enactment.[2]

When the organizing meeting of the Society finally convened in the partially

Continued on next page

Thayer retired as secretary-general manager of the State Medical Society of Wisconsin in 1987. Wolfe is a doctoral candidate in the history of science at the University of Wisconsin in Madison. Together they are researching and writing a social history of medical societies in Wisconsin funded in part by grants from the State Medical Society, the Medical Society of Milwaukee County, and the SMS Charitable, Educational and Scientific Foundation. Copyright 1992 by the State Medical Society of Wisconsin.

Continued from preceding page
completed Capitol building in Madison on Feb 3, 1842, Dr Cary was elected its first president.

Dr Cary

Born in Shoreham, Vt, on Dec 24, 1801, Dr Cary was educated in public schools and received his MD from Vermont's Castleton Medical College in 1822. He soon married and moved to Hannibal, NY, to establish a practice.[3]

In 1835, he joined the Western Emigrating Company in a move to settle a colony in southeast Wisconsin, then part of the Michigan Territory. The family took a schooner from Oswego, NY, and landed at Pike Creek, just north of the current city of Kenosha, in mid-August. Just before Christmas, Dr Cary moved his family to a heavily forested area near the mouth of the Root River, now Racine. There, he staked a claim and occupied a log house "without floor, doors or windows." His was the only family to stay that winter in Racine.

Shortly after the family arrived, a stranger attempted to jump Dr Cary's claim. When Dr Cary tried to run off the intruder, he was shot, "the ball passing through his right arm and into his side, under the shoulder blade." A messenger was sent via an Indian trail through the woods to Milwaukee to obtain a doctor.

After "much time" a "young and very small surgeon" arrived on the scene, a man whom Mrs Cary thought was "too insignificant" to attend her "unusually large" husband. Apparently the doctor did his work well, for Dr Cary recovered to carry the ball in his side for the rest of his life.[4]

Dr Cary was the sole physician in that corner of the Territory for some years, and his practice carried him by horseback as far as 40 miles one way. He kept his office and a drug story in Racine's first post office where, off and on for 25 years, he served as postmaster. An ardent Democrat, Dr Cary was the local party leader, serving as mayor, county board member and many other posts during his lifetime.

On one of several occasions when Dr Cary was removed as postmaster, he was charged with "malpractices in office." The *Wisconsin Enquirer* of Milwaukee took up his defense, alleging the ouster was "manufactured" for the purpose of "gratifying the private malice of the Editor of the (Milwaukee) *Sentinel.*" The *Enquirer* contended that Dr Cary's "only offense, which produced his removal, was an ardent attachment to democratic principles and a uniform opposition to such weathercock politicians and rogues as the *Sentinel* supports."[5]

Clearly, Dr Cary was a man with political as well as medical interests. His friendship with Governor Dodge resulted in Dr Cary's appointment as judge advocate general of the Territorial Militia in 1837, and as surgeon general of the militia with the rank of colonel in 1845. Dr Cary had several lots in the city of Racine, as well as numerous farm and woodlot holdings in the area, a number of lots in Madison, and 300 acres on the Mississippi River.[6] Thus, he often combined politics with personal business by attending sessions of the Legislature in Belmont, and later Madison, while at the same time visiting his land holdings.

> Dr Cary was frequently the focus of controversy and newspaper headlines.

Dr Cary was a large man, standing 6 feet, 2 inches tall and weighing more than 250 lbs. He was friendly, gregarious, warm-hearted, and popular as a physician, citizen, and politician. He was in some ways a lakeshore image of the typical western Wisconsin Jacksonian Democrat exemplified by Governor Dodge–a bit raucous, sometimes frivolous, and given to impetuosity.

Dr Cary was not above being "one of the boys." He presided at the election of one Captain Knapp to the state Legislature. The event was held in a log tavern, but with Knapp's election, the revelry got out of hand. "Dignity, sobriety and even temperance pledges were cast aside. A tar barrel ... was set afire ... dinner bells, sleigh bells, and cow bells added to the din ... charges of powder set off tree slumps ... speeches were made and many of the revelers were so intoxicated that they had to be taken to their homes.[7]

Dr Cary no doubt attempted to carry his vigorous, sometimes tempestuous, political ways over to the fledgling Medical Society. The minutes of the Society's first meeting reveal that, with Dr Cary presiding, the organizing doctors adopted a preliminary constitution, elected two new members (the annual limit in those days!), urged the formation of county societies, and ordered a survey of fees being charged by physicians around the Territory.[8]

Dr Cary tried, but failed, to bring about annual meetings of the Society in January 1843 and January 1844.[9] There could be several reasons for his failure, but practicality dictated that few physicians would make a 2- or 3-day horseback ride through rough country in mid-winter merely for the good of the scientific cause.

Dr Cary served as Society president until January 1845, when he was named to its first Board of Censors. His successor was Jesse Moore, MD, of Beloit, who became president at the same meeting in which he was elected a member of the Society.

Little is known of Dr Moore, who was born in 1793, apparently in Monroe County, NY. One account has him coming to Beloit "about 1845" via Delavan in Walworth County; another suggests he came from Yucatan, Central America. He died in 1869, leaving an estate valued at $448.50, including "1 Lot of Medicine ($10), 1 Lot of Surgical instruments ($15), 1 4 Blade Speculum ($4) and 1 Pocket Case ($6)."[10]

Although Dr Cary served a term as secretary of the Society, then 2 years as treasurer, he gradually retreated to his local practice and political life. For a time, he published a newspaper, then became interested in railroad development, the Racine Seminary, and the issue of emigration. He reportedly wrote several articles for the Leeds, England, *Mercury*, which resulted in many English families emigrating to Racine county.

In or out of political office, Dr Cary was frequently the focus of controversy and newspaper headlines. During the period from 1837 to 1860, the *Milwaukee Sentinel* alone carried at least 50 news items on him: his appointments, removal from office, reappointments, his night-time escape from a burning building, his attendance at meetings, his legal battles, and his activities as a publisher, churchman, and agent for the *Sentinel.*

Throughout his adventurous life, "Cary the physician" was a household word in the Racine area. When he died in February 1860, from complications of a carbuncle on his neck, the outpouring of the community was spontaneous and generous. The local citizens and press hailed him as a man "ever ready to succor the needy, and console the afflicted ... always ... ready to move in all things calculated to improve and advance; always willing with his purse and counsel to aid in projected benefits ... never ... unfaithful to the confidences so often reposed in him ... whose good qualities far outbalanced all imperfections.[11]

It is a bit ironic that for all his notoriety, for all his newsworthiness, no one for 150 years–until 1991–made note of Dr Bushnell Cary's singular place in the history of the State Medical Society. This is no reflection on the man; rather, it is a simple reminder that a medical society was not a high priority to either physicians or the public in the struggling frontier Territory of Wisconsin in the early 19th century.

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Glimpses into our past

Richard D. Sautter, MD, medical editor

OVER THE COURSE OF the next 12 issues, the *Wisconsin Medical Journal* will bring you a healthy dose of Wisconsin's medical history as part of the commemoration of the 150th anniversary of the SMS. And as part of that effort, I will provide you with occassional glimpses into our past. Some of the glimpses will spark memories, others will be enlightening; some will amuse, others will amaze: you will find all, I hope, either entertaining or interesting. Enjoy.

25 years ago

While Nero fiddled. The SMS president proclaimed that "ethereal physicians" had already allowed "half the house of medicine" to be "burned and destroyed," and called on his peers to consider reorganizing the SMS as a labor union for physicians.

Serving abroad. A number of Wisconsin physicians volunteered for the AMA's Project Vietnam, generally serving a 60-day tour. One such volunteer wrote in the *WMJ* that "The war casualties, who make up about 40% of our patient population, are the roughest emotionally.... In our hospital, we have baby amputees, paraplegic little boys, burned girl children, and old women mangled by shell fragments."

Healing social ills. Physicians were called upon to stem the rising tide of high school drop-outs. One author noted: "By being alert to emotional indications in his patients, by astute counselling, and by sympathetic demeanor, the family doctor can make an important contribution not only to the social and economic well-being of his patients, but also to reduction of a serious problem of our society."

50 years ago

Two causes. The *WMJ* took up two causes in a series of articles: World War II and nutrition. The articles carried headlines such as "Milk in national health," "Wisconsin cheese," "Emergency medical defense needs outlined," and "Physicians and tire rationing."

Advertising oddities. The *WMJ* carried ads for Coca-Cola soft drinks, Philip Morris cigarettes, Camel cigarettes, and California wines.

A call to duty. Wisconsin physicians were so quick to answer the call for volunteers

in World War II that government officials issued special warnings to physicians not to announce their departure to their patients, close their offices, and sell their equipment until they had heard for certain that their volunteer applications had been accepted.

The doctor as a person. Physician hobbies were on display at the SMS annual meeting. The exhibit included collections of stamps, bells, sea shells, glassware, pewter ware, and guns. Original works by physicians included soap carvings, paintings, waterfowl photographs and stuffed animals.

75 years ago

Some progress on TB. October 1917 was the first month in which more deaths in Wisconsin were attributed to cancer (164) than to tuberculosis (158), with pneumonia (165) "always" leading the list of causes of death.

An earlier call to duty. The *WMJ* carried an unsigned editorial calling for physicians to volunteer for the medical corps. "The United States is at war with the greatest military power the world has ever known. It is a death grapple for the survival of the principles of democracy.... Complaint comes from every section of the country that younger physicians ... are failing to respond to the call to the colors.... It is also a curious fact to note that the men in the larger cities are not doing their share (while) many of our country communities have been left without medical men.... A crisis not to be compared with anything in the history of the world is at hand."

Amazing objectivity. The *WMJ* noted that Dr O.L. Sapper, of Mayville, "who left in 1915 to join the German army has received his third decoration for bravery by order of the Kaiser."

100 years ago

Fighting TB. The SMS president, F.G. Witter, MD, delivered an impassioned speech calling on the federal government to fund research into tuberculosis. The amazing part, however, was the state of the federal government's budget: "Can it be that the free and enlightened government of the United States, *having in its treasury an unused surplus of receipts over expenditures* (emphasis added) mounting high into the millions, does not appreciate the need of providing for common defense against an invisible and relentless foe...."

The SMS urged, as part of its anti-tuberculosis campaign, that public schools abandon the practice of having all the children in one class share a single handkerchief, toothbrush, and toothpick.

Doctors fall shy of perfect. The SMS continued to fight for legislation that would add medicine to dentistry, law, and pharmacology as a profession licensed by the state and regulated by an examining board. "It is admitted," wrote Julius Noer, MD, "that it is quite possible that medicine and medical practitioners may, in course of the ages, naturally and spontaneously attain absolute perfection and rise above the need for legal restrictions of any kind ... (but) this stage of our evolutionary development is not in near sight...."

The licensing was opposed by the leading newspapers, one stating in an editorial that "the reality of cures by educated physicians rests on no better evidence than the reality of cures by Jim Lee, alias Gun Wa, by faith healers, by jim-jammie snapping doctors, or by impossible high dilutions of homeopathic medicines."[150th]

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

October 1991

* Allen, Herbert M., Neenah
* Alston, James A., Waukesha
* Breadon, George E., Monroe
* Garner, Harold B., Oconto Falls
* Groden, David L., Marshfield
Harris, Gerald J., Milwaukee
Hartjes, Thomas L., Middleton
* Hayden, John W., La Crosse
Hussa, John F., Hayward
* Kuglitsch, John F., Fond du Lac
* Lee, Jong Man, Beloit
* McKenna, John E., Antigo
* Nelsen, Paul D., Green Lake
* Richards, Marcia J.S., Milwaukee
* Sellers, Robert L., Superior
* Shewmake, Floyd F., Kenosha
* Spencer, Robert H., Menasha
* Wegehaupt, Paul K., Rhinelander
Wilson, Stuart D., Milwaukee
* Zoch, Thomas W., Marshfield[150th]

Rural Health CARING for the country

National Rural Health Association
15th Annual Conference on Rural Health
May 6–9, 1992
Hyatt Regency Crystal City
Washington, DC

County society news

Brown. Fifty members were present at the November meeting of the Brown County Medical Society to hear guest speaker Wesley E. McNeal, MD, speak on the medical and cultural aspects of China. New members accepted to membership are Stanley Adkisson, MD, John Gassner, MD, Helen Young, MD, and Gregory Cooley, MD.

Columbia-Marquette-Adams. Beatriz Somoza, MD, was recently elected a member of the Columbia-Marquette-Adams County Medical Society.

Dane. The following physicians have been accepted to membership in the Dane County Medical Society. They are: Thomas Grist, MD; Jose Perra, MD; Khosro Adib, MD; William Perloff, MD; Holly Duck, MD; Daniel Koster, MD; Robert Malin, MD; Todd Bokelman, MD; John Amuzu, MD; Thomas Berscheid, MD; William Wolach, MD; Jen Wong, MD; Karen Povinelli, MD; and Ronald Johnson, MD.

Kenosha. New officers of the society for 1992 are: Ricardo Rustia, MD, president; Kevin J. Fullin, MD, president elect; Michael J. Wempe, MD, past president; and Meredith Clubb, MD, secretary. Delegates are Kevin J. Fullin, MD; James L. Concannon, MD; Charles E. Pechous Jr, MD; Clifton E. Peterson, MD; and alternate delegates are Ernesto E. Buencamino, MD; Ramunuja R. Manda, MD; Roman Bilak, MD; and Michael Zeihen, MD.

Manitowoc. Anne Schuette, MD, Alexandra Logan, MD, John MacDonald, MD, and David Kuester, MD, have been elected to membership to the Manitowoc County Medical Society.

Marathon. Sally A. Browne, MD, was accepted to membership at the November meeting of the Marathon County Medical Society.

Oneida-Vilas. Twenty-five members were present at the November meeting of the Oneida-Vilas County Medical Society to hear Charles A. Kallick, MD, of Chicago, speak on the empiric theapy for serious infections. Danny A. Lundberg, MD; Loren R. Keldahl, MD; Richard Brandner, MD; Thomas S. Reich, MD; and Krishnan R. Varma, MD, were accepted to membership in the society.

Racine. Janet Lea Chene, MD, James P. Schieffer, MD, and Michelle Snyderman, MD, were elected to membership at the November meeting of the Racine County Medical Society.

Richland. New officers of the Richland County Medical Society for 1992 are: Neil N. Bard, MD, president; George Pfaltzgraff, MD, vice president; Richard W. Edwards, MD, secretary-treasurer and delegate to SMS; Thomas Richardson, MD, alternate delegate; and Richard W. Edwards, MD, county representative to the CES Foundation.

Rock. The guest speakers at the Rock County Medical Society were Larry Bergen, PhD, and G. Thomas Jones, MD, of Beloit. They took the pro and con position regarding the use of alcoholic beverages for medical purposes. New members accepted into the society were: Paul Anselmo, MD; Evelyn Archer, MD; Jeanne Arnold, MD; Allen Dunning, MD; Peter Jeffries, MD; Sheree Lauth, MD; Sharon Thomas-McKelvy, MD; Anne Means, MD; Ramaswamy Parthasrathy, MD; Christine Petty, MD; Christopher Pfaendtner, MD; David Pittenger, MD; Michael Rainiero, MD; Nancy Rainiero, MD; Mario Rojas, MD; Jyme Schafer, MD; Divya Sharma, MD; Julie Skinner, MD; Steven Stroman, MD; Gregory Wlodarski, MD; and Edward Wojciechowski, MD.

Rusk. The guest speaker at the October meeting of the Rusk County Medical Society was Ronald Landbloom, MD, from the St Paul Ramsey Medical Center, who gave a humorous presentation on depression awareness and treatment. Also present at the meeting was Brian Smiley, of Paine Weber & Associates from Madison, who answered questions on retirement plans and financial investment basics.

Vernon. Fifteen members and guests were present at the September meeting of the Vernon County Medical Society to hear guest speaker Sen Brian Rude speak on legislative health issues. At the November meeting of the society, Susan Lepinski, MD, gave a presentation on an update on upper gastrointestinal disorders.

Waukesha. Elizabeth Goldsmith-Zietlow, MD, Michael H. Knautz, MD, Mary J. Reznicek, MD, and Paul B. Young, MD, have become members of the Waukesha County Medical Society.

Obituaries

Chungki Lee, MD, 53, of Hartford, died Sept 18, 1991, in Hartford. Dr Lee was born April 10, 1938, in Korea, and graduated from the College of Medicine at Seoul National University. His internship was served at the Long Island College Hospital in New York, and his residency completed at Hartford Hospital in Connecticut. Prior to joining the Hartford Parkview Clinic in 1973, Dr Lee served fellowships in pediatrics at St. Francis Hospital in Hartford, New York University Hospital, and Lenox Hill Hospital in New York. He also served in the Korean Army from 1963 to 1966. He was a member of the Washington County Medical Society, the SMS, and the AMA. Surviving are his widow, Sanghie Lee and two daughters, Sue and Sarah.

Herbert W. Pohle, MD, 78, of Shorewood, died Oct 24, 1991, in Shorewood. Dr Pohle was born July 9, 1913, in Glen Haven, and graduated from the University of Wisconsin Medical School, in 1938. He served his internship at Researach Hospital in Kansas City, and his residency was completed at University Hospital and Clinics in Madison. Dr Pohle served in the US Army Medical Corps during World War II. He was a fellow, govenor, and regent of the American College of Physicians. He served as chief of staff at Milwaukee County General Hospital and also at Columbia Hospital in Milwaukee. He was a member of the Wisconsin Society of Internal Medicine and the Milwaukee Academy of Medicine. He also was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Betty; two sons, Dr Edward, of Thiensville, Dr William, of New York; and one daughter, Betsy Schneider, of El Dorado, Alaska.

Cyril J. Radl, MD, 84, of Manitowoc, died Oct 12, 1991, in Manitowoc. Dr Radl was born May 19, 1907, in Sleepy Eye, Minn, and graduated from Marquette University Medical School. He served an internship at Milwaukee County General Hospital. Dr Radl practiced in Wisconsin Dells for 7 years and then attended the University of Pennsylvania's School of Ophthalmology, completing a residency at the Episcopal Eye-Ear-Nose-Throat Hospital in Washington, DC. He served in the US Navy for 4 years as a flight surgeon. He practiced in Manitowoc from 1945 until his retirement in 1974. He was a member of the Manitowoc County Medical Society, the SMS, and the AMA. Surviving are his widow, Ruth; three daughters, Ann Radl, of Glastonbury, Conn, Joan von Germeten, of Boston, Susan Rusboldt, of Manitowoc; and seven grandchildren.

Eugene N. Wright, MD, 73, a former Oshkosh physician, died Oct 16, 1991, in Salem, SC. Dr Wright was born April 15, 1918, in East Conemaugh, Penn, and graduated from Hahnemann Medical College in Philadelphia. His internship and residency were completed at Huron Road Hospital, East Cleveland, Ohio. He served in the US Army during World War II. Prior to moving to Oshkosh in 1954, Dr Wright had practiced medicine in Ashtabula, Ohio. He retired from his medical practice in 1980. He was a fellow in the American College of Surgeons and also the American College of OB/GYN. He was a member of the Winnebago County Medical Society, the SMS, and the AMA. Surviving are his widow, Helen; two daughters, Janis Michels, of Oshkosh, Patricia Waskawic, of Omro; and one sons, Gene, of Santa Rosa, California.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.

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Minneapolis/St Paul, Minnesota. Opportunity available for BE/BC internist to join a large, established multi-specialty group practice in the metro Twin Cities area. Excellent compensation and benefits package. Contact: Nancy Borgstrom, Aspen Medical Group, 1020 Bandana Boulevard West, St Paul, MN 55108; ph 612-641-7170. EOE. 1/92

Internal medicine, family practice and obstetrics-gynecology practice opportunities. Rural lake country community is seeking the above practitioners to join an active 13 physician multi-specialty group. Quality, comfortable living environment, multiple recreational activities, fine educational opportunities and cultural activities abound. Opportunity includes relaxed call, liberal salary and exceptional benefits. Send curriculum vitae or inquires to: Lake Region Clinic, PC, Attn: Joel Rotvold, PO Box 1100, Devils Lake, ND 58301, or call collect at (701) 662-2157 for further information. 1/92

Pediatrics-Marshfield Clinic, a 400 physician multi-specialty group practice, is seeking BE/BC pediatricians to join expanding regional centers in Chippewa Falls and Rice Lake, Wisconsin. These are beautiful, wooded Wisconsin areas with an abundance of lakes, rivers and streams. Both communities offer a thriving economic environment, clean air, low crime, excellent schools and exceptional four season recreation. **Chippewa Falls** is a community of 22,000 with 8-10,000 permanent residents living around adjacent Lake Wissota. It borders Eau Claire, Wisconsin, a city of nearly 80,000 which includes a major campus of the University of Wisconsin. **Rice Lake** is a lakeside community of 8,500 people. In addition to excellent primary and secondary schools, both public and parochial, educational opportunities include a UW Center and VTAE campus. Both opportunities have beautiful new clinic buildings situated adjacent to comparably modern and progressive hospitals. In addition to their many local resources, the nearby proximity of major metropolitan areas (ie: 1 1/2 hours from Minneapolis/St Paul) provides a catalog of readily accessible cultural activities, shopping, fine dining and professional spectator sports. Each opportunity has it's own special qualities with more attractive features relative to individual needs and preferences. Emphasis on life-style and quality practice is combined with a guaranteed salary and outstanding fringe benefit package. If this combination of professional excellence and life-style made possible through the backup resources of a leading medical center in conjunction with the uncommon, varied beauty of Wisconsin's land and lakes sounds interesting to you, please send CV and references to: David L. Draves, Director Regional Development, 1000 North Oak Ave, Marshfield, Wisconsin 54449, or call 1-800-826-2345, extension 5376. 1/92

Staff psychiatrist. Medium-size smoke-free environment medical center offers primary and extended care to a large area of west central Wisconsin. Full range of psychiatric services include admissions (acute), geriatric, long-term care, out-patient, PTSD, and alcohol. Salary range to $119,500, depending on qualifications and board certification. Excellent benefits package includes malpractice protection, 30 days paid vacation, and annuity plan. Relocation expenses. 173-acre facility includes limited on-station housing and nine hole golf course. City of 7500 in a predominantly rural area that offers affordable real estate, good schools. Conveniently located on I-90/94 midway between Milwaukee and Minneapolis. Call or write: Eugene J. Traynor, MD, Chief, Psychiatry Service (116A), VA Medical Center, 500 East Veterans St, Tomah, WI 54660; 608-372-1631. EO/AAE. 1-4/92

Family practice physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD,MBA, PO box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 1-3/92

Seeking a BC/BE pediatrician, an internist, and an OB/GYN to join a well established eight physician expanding multi-specialty group. Location is a southeastern Wisconsin city of 36,000 and a drawing area of 85,000. 240 bed well-equipped hospital. Guaranteed salary for the first year. Please contact David Lawrence, MD, 92 East Division St, Fond du Lac, WI 54935; ph 414-921-0560 collect. 1tfn/92

Wisconsin. Fourth BC/BE obstetrician/gynecologist needed to join stable, progressive, primary-care based HMO/group practice in University town of 60,000 near Minneapolis/St Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact Stuart R. Lancer, MD, MBA, Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702; 715-836-8552. 1-3/92

Internal medicine physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD, MBA, PO Box 3217, Eau Claire, WI 54702; ph 715-836-8552. 1-3/92

The Wausau Medical Center is seeking board certified/eligible individuals in the following specialties: dermatology, family medicine, gastroenterology, hematology/oncology, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, walk-in (urgent care). Large multi-specialty group located in

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Physicians Exchange

Continued

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Family practice Wisconsin. Physician needed for partnership in broad based primary care practice in exceptional south central community. Shared call, fully-equipped and staffed office, very competitive guaranteed salary and comprehensive benefit package. For information on this and other opportunities in the upper Midwest, contact and send CV to Mary Jo Cordes, President, MDsearch, PO Box 21507, St Paul, MN 55121 or call 612-454-7291. FAX 612-454-7277. 12/91;1-3/92

General surgeon. Join established lucrative practice serving two excellent hospitals and two county population of 35,000. Peaceful scenic city of 8,500. Excellent housing, school system, shopping, progressive medical staff. Send CV to Jim Schneckloth, 4 Sunset Place, Charles City, Iowa 50616. 12/91;1-2/92

First Care Walk-in medical needs part-time physician (FP,GP,DO) for busy, fee-for-service clinic associated with St Elizabeth Hospital. Competitive salary, flexible hours. Contact: First Care North, F. Svatos, Director, 1225 W. Northland Ave, Appleton, WI 54914; ph 414-738-2005. 12/91;1-2/92

Family practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr. Paul Hayes' office 906-563-9255 or Dr. William Gladstone's home 906-563-8743. Anderson Memorial Hospital, Main Street, Norway, MI 49870, 906-563-9243 12/91;1/92

Established, four physician pediatric group seeks 5th practitioner. Practice is full range pediatric/adolescent medicine. Practice is moving to brand new facility next spring. Hospital facilities include 350 beds and level 2 nursery with all specialists and sub-specialists on staff. Community includes many recreational opportunities, especially water sports, quality education–public and parochial, strong economy, numerous museums and symphony. Housing options include many residential lake developments. Financial package includes salary, incentive bonus and relocation allowance. For complete information, send your CV to Tom Hart, of Harris Kovacs Alderman, 4170 Ashford-Dunwoody Rd, Suite 500, Atlanta, GA 30319, or call him at 800-347-7987, ext #1-144. 12/91;1-2/92

Family practice. Fine opportunity for growing and lucrative group practice. Progressive medical staff serves 61-bed hospital and county population of 19,000. Peaceful, scenic city of 8,500 with excellent housing, schools, shopping, hunting, sports, wide range of community and hospital/health services. Send CV to Jim Schneckloth, 4 Sunset Place, Charles City, Iowa 50616. 12/91;1-2/92

Ideal internal medicine practice. Excellent opportunity for BC/BE internist to establish a prosperous practice. Progressive 107-bed community hospital with a medical staff of 45 physicians and a service area population of over 45,000. Vibrant northern Michigan community with all summer and winter recreational activities. Very competitive first year guarantee with benefits. Send CV or contact: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Ave, Iron Mountain, MI 49801; 800-323-8856. 12/91;1/92

Southeast Wisconsin lakefront community. Urgent care and two family practitioners needed for expanding 37-physician multi-specialty group. Twenty minutes to Milwaukee, one hour to Chicago. Partnership possible within 18 months. Call or write Lee Fivenson, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; ph 1-800-338-7107. p12/91;1-2/9222

ASSOCIATE DIRECTOR

Offering an environment committed to optimal professional and personal quality of life, the Appleton Family Practice Residency seeks a board certified, residency-trained family physician to compliment a well balanced faculty and a superior group of 18 residents. Responsibilities include teaching in an evolving innovative curriculum, patient care, administration, and research. A community based two-hospital supported program operating in an independent clinic, we are affiliated with the University of Wisconsin School of Medicine in Madison. This program enjoys a high level of medical and business community support and thrives in an area blessed with excellent schools, a safe environment and a vibrant economic base. Contact John Allhiser, MD, Director, 229 South Morrison St, Appleton, WI 54911; ph 414-832-2789. 1-2/92

MEDICAL DIRECTOR

Primary care clinic immediate opportunity. 7:30-4:00 Mon-Fri. JSA Healthcare Corp, is looking for a primary care physician to direct and service the Troop Medical Clinic at Ft McCoy, located in Sparta, Wis. The clinic provides healthcare to active duty personnel, dependents and occupational health services to Ft McCoy. Position requires a MD or DO, with ambulatory care experience, current license in one of the fifty states and ACLS/BCLS. Competitive financial consideration is offered with paid malpractice/CME. No nights, no call, no weekends, no holidays! Contact Susan Bray 1-800-966-2811. 1-2/92

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12/91;1-5/92

Internal medicine. Two successful, young, BC internists seeking a third BE/BC internist in a picturesque family oriented community near Madison, Wisconsin. Modern office building contiguous to JCHA hospital. Generous guarantee plus benefits and subsequent partnership. For more complete information call Doris at 1-800-323-9567 or contact Dept 633 in care of the Journal. p12/91;1/92

Growing, four physician family practice in Oshkosh seeks another associate. Need is dictated by growth in the area and the practice. Each physician sets his own hours and pace and works about 4 1/2 days per week. The group will relocate into a new facility next year. If you enjoy water sports and recreation, Oshkosh is second to none. We also offer museums, symphony, quality schools, and two zoos. We are seeking a residency trained family practitioner who enjoys obstetrics. For complete information, send your CV to Tom Hart, of Harris Kovacs Alderman, 4170 Ashford-Dunwoody Road, Suite 500, Atlanta, GA 30319; or call him at 800-347-7987, ext #1-145.
11-12/91;1/92

Family practice. 5th BC/BE family physician needed for single-specialty group in Watertown. OB preferred but optional. Friendly community of 20,000 located less than one hour from both Milwaukee and Madison. Guaranteed income plus incentives allow $100,000+ first-year income potential. Send CV or call Lee Fivenson, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; 1-800-338-7107.
p11-12/91;1/92

BC/BE pediatrician to join group of six within 70 physician multi-specialty clinic. This growing and diverse practice offers a competitive salary plus incentive, insurances and benefits, excellent hospitals, schools, colleges, cultural and recreational activities in town of 60,000. Practice serves a tri-state area of 225,000 population. Send CV to Denis P. Albright, Director of Physician Recruiting, Medical Associates Clinic, PC, 1000 Langworthy, Dubuque, IA 52001, or call 319-589-9981.
11-12/91;1/92

Exciting ready-made practice opportunity. FP willing to do OB needed for our Lake Mills service area. Option to join one of two existing clinics. Both have excellent call coverage schedules. OB/GYN specialists available in Fort Atkinson at hospital to consult, etc. For more information, please contact: Christine Humphrey, Fort Atkinson Memorial Hospital, Inc, 611 East Sherman Ave, Fort Atkinson, WI 53538; ph 800-421-4677, ext 5190 or 414-568-5190. 11-12/91;1/92

Internist to join two internists in active practice in scenic Upper Michigan. Medical school affiliation. Contact North Shore Internal Medicine, 2420 First Ave South, Escanaba, MI 49829; ph 906-786-1563. p11tfn/91

Family practitioner to join a progressive 13-physician group practice. Rural college town 30 miles from St. Paul, Minnesota, new clinic and constructing new hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. c9tfn/91

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9-12/91;1-2/92

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10-12/91;1-3/92

Beloit Clinic, SC, an expanding 45 physician, multi-specialty group in southern Wisconsin college town, is seeking a plastic surgeon, pulmonologist, a rheumatologist, an OB/GYN, and orthopaedic surgeon, a pediatrician, a physiatrist, and urgent care. Guaranteed salary with incentive, plus excellent fringe benefits. Send CV to James F. Ruethling, Administrator, Beloit Clinic, SC, 1905 Huebbe Parkway, Beloit, WI 53511; ph 608-364-2200.
11-12/91;1/92

Oshkosh, Wisconsin. Single specialty groups are recruiting in family practice, pediatrics, OB/BYN, and cardiology. Oshkosh is an attractive community of 55,000 people, located on the shores of Lake Winnebago and in the heart of Wisconsin's beautiful Fox River Valley. Competitive financial packages. Contact Christopher Kashnig, Physician Recruiter, Mercy Medical Center, 631 Hazel St, Oshkosh, WI 54902, or call 800-242-5650, X2430 or 414-236-2430.
1-3/92

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Physicians Exchange

Continued

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Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

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Contents

February 1992 Vol. 91 No. 2

Opinions

59 *President's page*
The challenge to medical schools
'Medicina nusquam non est' (medicine is universal): IX
by Cyril M. "Kim" Hetsko, MD, Madison

60 *Secretary's report*
There's nothing like a cheap shot
by Thomas L. Adams, CAE

63 *Editorial*
An enemy in the mirror
by Jeffrey H. Lamont, MD, Wausau

64 *Letters*
Don't shoot me, I'm just the doctor
by James J. Dickman, II, MD, Black River Falls

66 *Soundings*
Allegory Harry in the year 2020
by James P. Fogarty, MD, Barron

Scientific

67 The history and current status of nurse-midwifery in Wisconsin
by Karen E. Glasser, BA; Cynthia DeLano, CNM; and Paul D. Silva, MD, La Crosse

71 Herpetic esophagitis in an immunocompetent boy
by Michael J. Chusid, MD; Herbert W. Oechler, MD; and Steven L. Werlin, MD, Milwaukee

73 *Special*
Physicians, pinstripes, and prevention: Wisconsin data
by James E. Cassanova, MD, and Rick D. Gillis, MD, Milwaukee

Socioeconomic

75 The Americans with Disability Acts
by Sally Wencel, JD, SMS assistant corporate counsel

88 *Public health*
Policy implications of increased heart disease mortality
by Frank M. MacDonald, MD, Bayfield

Organizational

91 Discovery at Prairie du Chien: the story of Dr William Beaumont

94 A glimpse into our past
by Richard D. Sautter, MD, *medical editor*

95 SMS Board of Directors adopts new guidelines on HIV-infected health care workers

96 Physician briefs

101 County society news

102 SMS secretary-general manager travels to the shores of Lake Michigan

103 Charitable, Educational and Scientific Foundation donors

107 Obituaries

Our cover: The Dr William Beaumont and family (courtesy of the Ft Crawford Medical Museum in Prairie du Chien). See the related article on page 91.

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President's page

The challenge to medical schools

'Medicina nusquam non est' (medicine is universal): IX

THE ISSUES OF ACCESS to and costs of health care continue to percolate in Wisconsin and around the country this winter, and the SMS and AMA continue to encourage discussion of these important concerns.

As I have been pointing out in this monthly column, the issues of access to high quality, cost-effective care needs to remain non-partisan and solutions of diverse approaches should be respectfully and openly considered. All sectors of American society–the general public, physicians, patients, hospitals, insurance companies, employers, employees and the state and federal governments–must take responsibility for meeting their obligations in achieving this goal. This includes, of course, our medical schools.

The medical schools of this state and country should continue to provide leadership and scholarly input in helping to mold the future health care delivery system. These institutions should not lose sight of these obligations and should be role models for students, physicians, and society as a whole.

In Wisconsin, commendable efforts have been recently undertaken by the medical schools, especially in the Milwaukee area, to expand community health services. Efforts such as the Area Health Education Center, under development jointly by both of Wisconsin's medical schools, need to be encouraged. More needs to be done, especially in encouraging students to enter primary care, to serve in rural and urban under-served areas, and to adopt the attitudes that lead to the delivery of cost-effective, high quality care. In doing this, medical schools should strive to expand the involvement of students and house staff in existing community facilities while avoiding some of the pitfalls of reduplicative competition with the private sector for those covered by insurance or the "edifice complex" with the construction of expensive buildings. My hope is that those medical school leaders will continue to be heard who demonstrate the ideals of providing community service and cost-effective care in addition to research and

Continued on next page

Cyril M. "Kim" Hetsko, MD

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education.

I challenge the medical schools to continue to inculcate in their students the arts of compassion, caring, and primary care, along with the latest high-tech science. High technology has limited value unless it can be delivered to the patients who need it.

I challenge the medical schools to revitalize the old "Wisconsin idea" of helping to develop and effectively communicate the latest technology to all parts of the state so that all of our physicians can continue to deliver high-tech medical care in a cost-effective manner.

We have excellent medical schools and an excellent health care system in Wisconsin, but improvements can make them better. All the players on the health care delivery team must work together to build on the inherent strengths of the system in Wisconsin and further improve the health of our citizens.[150th]

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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Secretary's report

There's nothing like a cheap shot

The *Milwaukee Journal* recently ran an editorial that offered deserved praise for a group of Medical College of Wisconsin seniors who are donating their time to provide free health care to the uninsured at Milwaukee's Isaac Coggs Health Clinic. Similar tribute was paid to the students, residents and faculty members who are serving the homeless at Milwaukee's Family Crisis Center. The *Journal* advocated replication of these programs wherever possible. Up to this point, I found myself agreeing with the editorial and feeling proud of these future physicians and their mentors. Then, in the final two lines, the *Journal* took a cheap shot and called for volunteers from physicians in private practice-assuming and implying that such volunteers do not yet exist. Everybody knows that today's doctor is only in it for money, right?

I am eager to point out to the *Journal* and its readers that the medical students and physicians applauded in the editorial are merely embracing and perpetuating medicine's oldest tradition: compassion. Not to take anything away from their good work, but these students and residents are hardly alone, hardly an anomaly.

There are dangers in thinking that all we need is more volunteer doctors. First, such thinking allows us to ignore that limited access to health care is a problem created by everyone in the health care arena, including doctors and patients, hospitals and clinics, insurance companies and employers, and the state and federal governments. The more of us who pitch in-and there is no segment of society that does not bear some responsibility-the quicker we will find a solution to the problems of access to health care. Any remedy that addresses only one or two of this body's parts will fail to cure the ailment. Physicians cannot solve it alone.

Second, this sort of thinking tends to ignore the acts of generosity that are going on-quietly, without public acclaim -in doctors' offices every day.

Thomas L. Adams, CAE

David Kindig, MD, PhD, and Santiago

Continued on page 62

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Continued from page 60

Lastiri-Quiros, MD, both of the University of Wisconsin, conducted a statewide study of the free and discounted care given by Wisconsin physicians (*JAMA*. 1991;265:2982-2986). That study found that Wisconsin's uninsured and indigent patients receive $20,900 *per physician* in uncompensated and discounted health care–a total that reaches nearly 8% of total billings for a year (1988). Broken down into categories of contribution, the average physician provides $7,500 in discounted Medicaid services, $9,100 in debts written off, and free health care valued at $4,300. The study also found that the amount of charity care had increased between 1983 and 1988; and given the state of the economy, I think it is fair to assume the amount of charity care has continued to increase between 1988 and 1992.

Scholarly studies and statistics are not the only measure of Wisconsin's doctors' compassion. Each year, the SMS asks the public to nominate physicians for our Physician-Citizen of the Year award, and the public's response is an overwhelming outpouring of gratitude, respect and genuine love for Wisconsin's physicians. The stack of nominations is awash in acts of personal charity: bills for medical services that simply never were sent; sample medications dispensed to patients who could not afford to buy their prescriptions; clothing, outgrown by the physician's own children, quietly passed on to the families of less fortunate patients; and bright new toys delivered to fill otherwise empty Christmas stockings. There is the doctor who travels more than 100 miles each week to provide a small town its only health care. There is the doctor who visits the senior citizen center to teach woodworking and serenade with his banjo. And there are the doctors who deliver groceries to shut-ins, raise funds to buy vaccines for needy children, make house calls, serve as anti-drug abuse educators, volunteer for rescue squads, and stand beside us as we bury our loved ones.

I have said it before, and I am certain to say it again: Deeper than buyer and seller, provider and consumer, or physicians and patient, medicine is a human-to-human interaction that requires and inspires that which is most noble in us. This is not to say that medicine is without the ignoble, or without selfishness and scoundrels, but rather that compassion is its essence. And those medical students and residents serving Milwaukee's most needy patients are following in footsteps that are at once ancient and fresh.[150th]

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Editorial

An enemy in the mirror

We all have our opinions about the role of government in medicine. We know in our hearts that government is cumbersome and obtrusive, and that we as physicians can run the business of medicine far more fairly, efficiently, and compassionately than the government can. I would like to share a couple of vignettes with you, however, which, while not justifying heavy-handed government bureaucracy, may illustrate the pressure that government feels to exert greater control over the provision and reimbursement of health care.

The first illustration involves a friend of mine who is a singer. As she describes it, "singing isn't my life, or my living, but it makes my life more worth living." Not long ago, she began having problems with chronic sinus inflammation, and when medical management failed, agreed to undergo a sinus irrigation and debridement. The procedure, done under general anesthesia in an outpatient surgery center took 45 minutes. My friend received a bill from her surgeon for almost $9,000.

Thinking that there must have been one too many zero's typed in by mistake, my friend contacted the surgeon's office, only to be told that she had indeed been billed correctly. She was advised that the surgeon expected to collect about half of that amount from her insurance company. In answer to her horrified inquiry as to whether she would be held personally responsible for the remainder, she was advised that the surgeon would "probably" simply write it off.

My friend called me, long distance yet, outraged. "My father's open heart surgery cost less than that just 2 years ago," she stormed. "If that's the way you and your colleagues work the system, I want you to know that I think it stinks!"

I asked her if she felt her family had been fairly billed by their pediatrician, obstetrician, and internist. She acknowledge that she felt that each of these individuals had billed appropriately for services provided. It was obvious, though that she was still angry.

The other instance involved a colleague who had been hired as a family practitioner to staff a newly formed hospital-based clinic in a rural community. Being blessed with the "four *A*s," his practice thrived, even though a large medical center in a distant city already had a satellite clinic in the town where he practiced. Their physicians admitted to his hospital and wanted the hospital to invest in various pieces of expensive diagnostic equipment for the benefit of their visiting specialists. None of this bothered the independent physician, who continued to do well in his solo practice.

Over the next several months, the independent physician became busy enough that he sought permission from his hospital employer to recruit a partner. He was understandably surprised when the hospital refused. This surprise was nothing, however, compared to the shock he felt when the hospital administrator further informed him that his clinic was to be terminated. The independent physician protested, stating that the clinic was busy, was meeting hospital financial projections, and filled a need in the community. The physician pointed out that he had never been the subject of any sort of patient complaints, and that he practiced a high level of medical care. The hospital administrator refused to give a reason for the termination of the clinic, citing only a "cash flow problem."

> "If that's the way you . . . work the system . . . I think it stinks!"

It was not long after this that the independent physician discovered two interesting facts. Prior to the announcement that the hospital-based clinic would be closed, the physicians from the satellite clinic had been "behind" in signing their medical records, thus tying up several hundred thousand dollars in accounts receivable, a not inconsiderable sum for a small rural hospital. The interesting thing is that around the time of the announcement of the closing of the clinic, the delinquent charts were promptly taken care of, and there has since been no recurrence of the "cash flow problem."

Now, how each of you feel about these incidents is your personal business. You should know, however, that each of these occurrences resulted in letters being written. Those letters were not addressed to local newspaper editors, or to state insurance commissioners, or to state medical societies. Those letters of complaint were addressed to legislators, and those letters identified physicians as major bad guys.

"Wait a minute," you say, "there must be more to this than you're letting on." I didn't get the feeling that either the singer or the doc was lying or exaggerating. Why would they? They're people like most of us, more likely to let things go than complain. I am only telling you what I was told; more importantly, I am only telling you what the *legislators* were told.

The sad fact is that it was not just a singer and an independent family practitioner who were involved in these instances. The entire medical profession was maligned, not by the public, not by the press, *but by some of its own members*. There is no way that the most impassioned testimony by any of you or by organized medicine itself can undo the impressions created by the letters written about these occurrences.

There are two perceptions of physicians which are unfortunately persistent and popular with the public. One is that physicians are at best very well compen-

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sated for the work that they do, and at worst are downright greedy. The second is that physicians hate competition and are not above resorting to a little underhanded bad-mouthing of a colleague–or worse–in the cause of economic enhancement. These two incidents reinforce the worst physician and corporate medicine stereotypes.

Legislators are sensitive to those who elected them–and they only know what they are told. As happy as my singing friend is with her family's other physicians, she is unlikely to sit down and write letters extolling their virtues; and one would hardly expect a physician to write his legislators to praise colleagues who represented economic competition and yet strove to maintain cordial professional relations in the community.

It may well be that some legislators will now see a certain wisdom in HCFA's proposed "behavior offset" reduction factor in RBRVS. It may well be that some legislators will now perceive a need to more tightly control the economic activity of HMOs and clinics. If they do, it will be in response to a demand for action from their constituents, spurred on by a strong desire among members of Congress to redirect public outrage over undeserved financial privilege away from themselves.

Think about it. Think about what happened. Then think about the people and issues involved. Finally, think about the professional fraternity that preaches about the high standards and lofty ideals it expects of its members–yet too often stands accused of failing to practice what it preaches.

The Pogo cartoonist Walt Kelly said it best when he commented on the Watergate scandal of the early 1970s and its significance to the American public: "We have met the enemy, and he is us."

–Jeffrey H. Lamont, MD
Wausau[150th]

Letter

Don't shoot me, I'm just the doctor

To the editor: I understand with the new fee schedules being placed by Medicare that the physician behavioral reimbursement penalty is still present within the structure.

I cannot think of anything more demeaning to myself as a primary care provider in a rural area, who is already only making about 60 cents on the dollar charge for Medicare patients and Medicaid patients, than implying that I will crank up the numbers that I see to make up for a difference in pay schedule. I am already more than swamped with trying to take care of patients the best I can. I certainly am not going to try and increase any type of monetary benefits by trying to see more patients, especially those that are already losers financially! Congress had already addressed questions with the MVSP legislation.

It simply boggles my mind the type of rationalization thinking that must be going on in Washington. If somebody is trying to balance the budget, then call it what it is, but please don't hang me and then shoot me as a criminal while I am trying my best to provide care to the elderly and the poor in our rural area!

I am getting very tired of working 60 hour weeks giving rural health care, doing OB and call rotation and then to be made defensive and paranoid for accepting pens from drug companies; audited by WiPRO and Medicare for every little second guessed retrospective finger wagging; attorneys making big bucks at my premium expenses; and general expectations for perfection by everyone in the country. We are becoming an increasingly "sick" society!

The behavioral offset penalty of any amount insults not only my integrity but my intelligence as well.

–James J. Dickman, II, MD
Black River Falls[150th]

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Soundings

Allegory Harry in the year 2020

HARRY GAZED at the mounds of paperwork on his desk. The year was 2020. The 30 years since he started the gas station had seen the evolution of not only government regulation of his business but also an active role of the government in the payment received for his gasoline.

He read the headlines in a newspaper which cried out for cost containment of gasoline and a need for government to control these costs. He wondered how he got into this predicament and how society could be so naive to think that government could better control costs.

It all began with a moral responsibility of society to pay for the gasoline of the elderly. This system, however, quickly expanded to involve those disabled, single parents, and anyone deemed indigent. Almost 50% of the gasoline he sold went through the hands of the government and its ever tightening control.

Initially, his payments received for a gallon of gasoline was comparable to what the private sector was paying. The program quickly became over-used, with no financial restraints on those using the gas, causing the government to quickly establish a lower value for the gasoline. Changes in the price the private sector paid for the gasoline had to be altered to reflect the decrease in return from the government entitled sector.

New mandates received by Harry made him shudder. To balance the federal budget, the total value for all the gas sold at stations in the United States would be issued for a year. If that total value was used up, the individuals owning the service station would be required to issue gas for "free." In addition, a 5% decrease in the amount Harry could charge for the gas was issued for that year. On top of this was another 6.5% decrease in what Harry could charge for the gasoline. The explanation of this 6.5% decrease was that, since he would be making less on the gasoline to begin with at a decrease of 5%, he would make a behavioral adjustment and sell more gas to make up the difference in his profits. Harry couldn't quite understand the logic behind that, but then logic plays little part in this game.

A great deal of anger flushed his face as he opened the letter from GASPRO, a private bureaucracy paid to find fault with the way Harry ran his gas station. They had just issued a 5-point potential quality control problem in which he failed to document the oil level checked on one of his customer's vehicles. A denial of payment came with the letter with the standard response that he had 30 days to challenge their findings.

Harry began to think that maybe it was time to get out of the gas station business and try something different, something that returned to the old beliefs of individuals interacting in a free market without the restraints of government control. He began to realize that individual freedom cannot exist in an atmosphere where economic freedom does not. He began to think, as the bell rang with another entitled customer demanding his presence immediately, maybe it is too late for all of us.

–James P. Fogarty, MD
Barron[150th]

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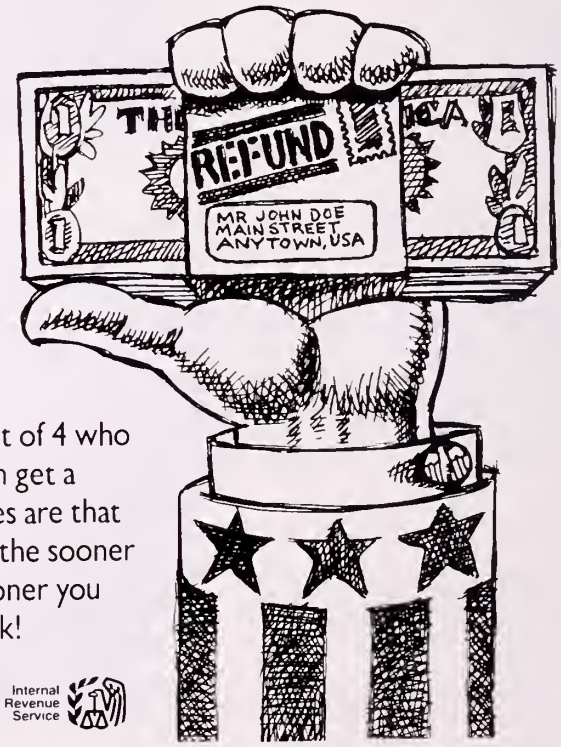

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The history and current status of nurse midwifery in Wisconsin

Karen E. Glasser, BA; Cynthia DeLano, CNM; and Paul D. Silva, MD, La Crosse

Two editorials in the June 1991 *Wisconsin Medical Journal* communicated a concern for the equitable provision of health care to all Wisconsin residents.[1,2] They requested greater commitment to this goal by the state government, and cited quality obstetric care as a worthwhile investment of the public dollar for long-term public health. As part of the discussion of resources available to improve obstetrical care, this paper will present a summary of the current status and potential expansion of midwifery practice in Wisconsin after a synopsis of the relevant historical information. *Wis Med J.* 1992:91(2):67-70.

An historical study of midwifery practice in Wisconsin[3] indicates that it was a thriving profession in the early part of the century, consisting largely of immigrants from central and northern Europe. The midwives were often motivated for practice by the financial needs of their families, and structured their practices around the families' schedules. In rural areas they were often "neighbor women," trained informally through their own labor experience and assisting other midwives. In more populated areas of the state, training ranged from apprenticeship, often with an experienced physician, to a 2- to 6-month course at a midwifery school. The lack of unifying elements among the midwives prevented the development of lay midwifery into a profession as the country became increasingly settled.[1] It also declined with the professionalization of medicine and the understanding of birth in increasingly scientific terms.[4]

To a lesser degree, lay midwifery is still practiced in Wisconsin and continues to have some minor influences on the medical community. One factor in the continued use of lay midwives is the preference for home delivery among some women, which generally precludes physician or nurse midwife attendance.[5] Among Amish communities, for example, hospital births are the exception. Unfortunately, there is little current data on the obstetrical outcome of lay midwife care; generally only anecdotal reports of wonderful experiences or obstetrical disasters are available.

From the Department of Obstetrics and Gynecology of the Gundersen/Lutheran Medical Center in La Crosse. Funding for this project supported by a grant from the Gundersen Medical Foundation.Reprint requests to: Paul D. Silva, MD, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. Copyright 1992 by the State Medical Society of Wisconsin.

Early nurse midwifery

In the early part of the 20th century, maternal and perinatal morbidity and mortality rates were high, and the practices of lay midwives were largely blamed for the problem. The 1921 Sheppard-Towner Midwife Training Act was implemented to train and regulate the existing lay midwives, but their care was perceived by many policy makers as a stopgap to meet the existing need until more obstetricians were trained and able to care for the volume of patients. Support for the program dwindled as increasing numbers of women turned to hospitals and physician care, and funds for the program were withdrawn in 1929, with the need for maternal health care in many areas of the country still unmet.[6]

Nurse midwifery has been differentiated from lay midwifery since its introduction into the United States. The first nurse midwife service in the United States, the Frontier Nursing Service (FNS), was implemented by Mary Breckenridge in Kentucky in the mid-1920s.[7] Breckinridge approached nurse midwifery from a concern for public health, believing and demonstrating that the care was an efficacious means of meeting the needs of the medically under-served people in the United States. Because there were no nurse midwifery training programs in the United States, Breckenridge had recruited

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her staff from training programs in Great Britain. The nurse midwives worked in a large territory from a central location, described as a corps of "nurses on horseback."[7]

Development of nurse midwifery

Although the Kentucky service provided an effective model for the use of nurse midwifery, professionalization in the field developed slowly. Many concerns had been raised for the maternal health needs of urban populations, and New York's Lobenstine Midwifery Clinic was established in 1931, with an affiliated school opening in 1932. Both were incorporated into the Maternity Center Association in 1935, and into the State University of New York Downstate Medical Center in 1958.[8] Eleven other schools for nurse midwife training were established between 1932 and 1965; five subsequently closed. In the 1950s and 1960s, graduating nurse midwives had few opportunities for practice, and many either taught at the existing schools or served overseas.[9]

The American College of Nurse Midwifery (ACNM) was established in 1955, formed from the nurse midwife section of the National Organization of Public Health Nurses (NOPHN). In the late 1960s, it merged with the American Association of Nurse Midwives (an alumni organization of the FNS) to form the American College of Nurse Midwives,[8] recognizing its members as certified nurse midwives (CNMs). The *Bulletin* of the ACNM (later to be called the *Journal of Nurse Midwifery*) began to be published in 1955, assisting in the process of professionalization by providing a forum for the discussion of topics relevant to establishing and maintaining nurse midwife practice.

Statements on nurse midwifery legislation were issued by the ACNM in 1974, and work was begun to attain consistent regulation pertaining to nurse midwife practice from state to state. A 1976 review of the existing statutes revealed great disparity in the recognition and supervision of nurse midwifery. The ACNM sought legislation which specifically recognized nurse midwifery in its statutes and regulations; there were 19 such states in 1976, with legislation pending in eight states. Wisconsin's statutes, in contrast, were among the most ill-defined and restrictive. This assessment was based on a letter from the attorney general to the secretary of the Medical Examining Board in 1973, which interpreted the 1953 repeal of statutes pertaining to midwife licensure as a restriction of midwives from full practice.[10]

In 1980, federal legislation was enacted to mandate the inclusion of nurse midwives in state Medicaid programs. Review of the legislation in 1984 showed that only 29 jurisdictions were in compliance with the Medicaid legislation, although the number of states which specifically recognized nurse midwifery had increased to 40.[10] Wisconsin's statutes had been amended in 1980 to include nurse midwifery under a separate section of the Nurse Practice Act, requiring both ACNM certification and registration as a professional nurse in Wisconsin, but Medicaid reimbursement was unavailable until April 1985.

As of the most recent review in 1987, nurse midwives were specifically named in 43 of the jurisdictions' statutes or regulations. Medicaid reimbursement for nurse midwifery practice was available at that time in 35 of the 52 jurisdictions.[10]

The value of nurse midwifery

In conjunction with professional organization and certification, the volume of nurse midwife work across the United States has increased greatly during the last 15 years, expanding from 19,686 midwife attended births in 1975 to 115,886 in 1988.[11] This increase in case load has been facilitated by greater public confidence in midwife care. Studies have indicated that continuous supportive care given by midwives may be beneficial in normal labors.[12]

Nurse midwifery services have also been sought in the public sector for medically under-served populations. The 1988 report from the Institute of Medicine's Committee to study Outreach for Prenatal Care cite the use of nurse midwifery programs as central to "increasing the capacity of prenatal care systems," as well as useful in restructuring the existing maternal care system.[13] Evidence for this recommendation comes from pilot programs which have demonstrated good statistical results. An early 1960s demonstration program in California, funded by the state to provide services for rural, indigent women, also demonstrated a decrease in neonatal mortality (from 23.9 to 10.3 per 1000 live births) which rose sharply (to 32.1) after the program was ended.[14] Statistics from the service at New York City's North Central Bronx Hospital, established in 1979, indicated lower perinatal mortality rates (14.5/1000 births) than the overall New York City rates (15.9/1000), or rates from other municipal hospitals (20.6/1000). In this service, both high- and low-risk women are under midwife care, with obstetric and pediatric backup if necessary.[15]

Strong nurse midwifery programs are beneficial to physicians as well, freeing them for more specialized care. It is estimated that 12% of practicing obstetricians have stopped delivering babies, while 30% do not handle deliveries after age 45.[16] In a team approach, midwives provide cost-effective, one-on-one care in low-risk pregnancies, complementing the tertiary care given by physicians. In addition, results from a 1989 practice survey indicated that nurse midwives were participating more in the care of high risk women, and that 80% of the respondents were providing continuity of care to 70% of their clients. This information may indicate potential for the increased participation of nurse midwives in a cooperative health care system that provides adequate medical backup.[17]

A survey of obstetrician/gynecologists conducted in 1971 indicated that the implementation of educational programs facilitates the cooperation between nurse-midwives and other health care professionals.[18] Because the "range of normal" to which midwives are prepared to respond depends greatly on the situation and the level of trust between the physician and the nurse midwife,[19] the fostering of professional respect through education may have a positive influence on the strength of nurse midwife services.

Nurse midwifery in Wisconsin

There are currently 10 nurse midwifery practices in Wisconsin, employing 26 of the 55 certified nurse midwives in the state. Four practices exist in Milwaukee, and one each in Neenah, Madison, Wausau, Eau Claire, La Crosse, and Sparta.

A recent review of the La Crosse practice (at the Gundersen/Lutheran Medical Center) reveals it to be a good example of how, with appropriate physician consultation, nurse midwives can satisfactorily care for a large number of obstetrical patients. There has been a steady rise in the volume of the nurse midwifery service over its 15-year history and it now accounts for approximately 40% of the antepartum visits and deliveries. The service currently employs six nurse-midwives, who work under the supervision of the staff obstetricians. Women may be cared for jointly by a physician and a nurse midwife if complications develop after the woman has selected midwife care. The emphasis of the practice is on close communication between all the medical professionals involved in the woman's care, to insure prompt referral and management of problematic pregnancies.[20]

The education crisis

The increased demand for midwife care has occurred in conjunction with a decline in students enrolled in the various programs throughout the nation, from an average of 257 graduates in 1980 to 172 in 1989. The crisis in midwife education has been much discussed in the recent volumes of the *Journal of Nurse Midwifery*, and is attributed to a variety of factors. The increasing cost of education without greater government support, the availability of more career options for women, and the malpractice crisis are all thought to deter potential students.[21] Many students of nurse midwifery pursue training after an "incubation period" of up to 10 years following their initial interest in the profession, and have differing educational needs which may not be met by "standardized" education.[22] In addition, there is a shortage of experienced teachers.

For the profession of nurse midwifery to continue to serve both the public and the private sector, the existing education programs must be adapted to meet the needs of potential students.[23] Although 32 certification programs currently exist, there is a need for increased geographic and economic accessibility to facilitate greater enrollment.

Wisconsin's response to the crisis

In Wisconsin, the problem of the inaccessibility of education is being addressed by two budgetary proposals which have recently been brought before the state Legislature. One would allocate funds for loan assistance to midwives in exchange

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for 5 years' practice in medically underserved areas. The other proposal would provide for the establishment of a committee, consisting of a representative from each of five nursing schools, to discuss the establishment of a master's degree program in nurse midwifery in Wisconsin. The implementation of such a program would make nurse midwife training more accessible to Wisconsin residents, and ideally result in an increase in the number of practicing nurse midwives in the state. Today, Wisconsin faces problems in providing maternal health care to its residents in various areas of the state. The state's obstetricians are most concentrated in the areas of La Crosse, Marshfield, the Fox Valley area, Madison, and Milwaukee, while 11 counties have no practicing obstetricians. For a variety of reasons, there has also been a reduction in the percentage of family practitioners willing to provide obstetrical care. The use of nurse midwifery services is of benefit in meeting these needs. Adequate education programs are necessary for them to become a viable part of Wisconsin's health system, and financial assistance will enable individuals to pursue the education necessary to assist their communities.

Physicians, as part of the team of health care providers, benefit from the sustenance of nurse midwifery. Their continued use and recruitment of CNMs is demonstrating to state legislators the necessity of approving pertinent legislation, and will enable nurse midwives to contribute more effectively to improving maternal and child health in Wisconsin.

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150th

Tell us about your most unforgettable physician

As part of the introspection and reflection that comes naturally to an organization turning 150 years old, the *Wisconsin Medical Journal* would like to feature the colorful, the admirable, and the unforgettable physicians of Wisconsin--past and present. If you know of a physician who you think may merit being featured in the *WMJ*, drop us a line telling us who and why. Or, if you prefer, write the story yourself and submit it for consideration. We can't promise to feature everyone suggested, but we'll strive for a good sampling.

Write to: "Historical Profiles" c/o *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.

Herpetic esophagitis in an immunocompetent boy

Michael J. Chusid, MD; Herbert W. Oechler, MD; and Steven L. Werlin, MD, Milwaukee

An immunocompetent 12-year-old boy had epigastric pain, odynophagia, fever, and hematemesis. Esophagoscopy demonstrated ulceration of his proximal and distal esophagus. Although histopathologic analysis of biopsies obtained from the lesions was nondiagnostic, herpes simplex virus type 1 was isolated from these samples. The patient responded rapidly to acyclovir therapy. Only a handful of cases of herpes esophagitis have been reported previously in immunocompetent children. This infection must be considered in children having odynophagia and fever, even if they are not immune compromised. *Wis Med J.* 1992;91(2):71-72.

While herpes simplex esophagitis is a frequent infection of immunocompromised patients, increasing numbers of immunocompetent adults with herpetic esophagitis have been reported.[1-10] Reports of herpes esophagitis in non-immunocompromised children remain unusual.[1,10-12] We recently treated an immunocompetent 12-year-old boy admitted with fever, persistent vomiting, and hematemesis but without oropharyngeal lesions at the time of admission, who was ultimately diagnosed as having herpetic esophagitis and whose symptoms responded dramatically to acyclovir.

Case report

A 12-year-old boy was admitted to Children's Hospital of Wisconsin because of persistent vomiting and hematemesis. On the day of admission he was seen in the emergency room for persistent vomiting and abdominal pain for 3 days. His temperature was 38.4°C, pulse rate 110, BP 112/70. His posterior pharynx was slightly inflamed but no lesions were seen. The patient was felt to have gastroenteritis and to be dehydrated. Intravenous Ringer's lactate solution and acetaminophen suppositories were administered and he was sent home.

He returned to the emergency room 10 hours later because of increasing vomiting, and emesis of coffee ground material and fresh blood. He was tentatively diagnosed as having a possible Mallory-Weiss tear. On admission to the hospital, intravenous fluids and cimetidine were administered. On the first hospital day he was febrile to 39°C, and his upper abdominal pain worsened. He had repeated emesis of bile and brownish guaiac positive material. Although he continued to complain of a sore throat, no oral lesions were noted.

On the third hospital day, esophagogastroduodenoscopy was performed. Shallow ulcers were noted on the posterior pharyngeal wall extending into the upper third of his esophagus. The middle third of the esophagus was uninvolved, but the lower third demonstrated large irregularly shaped confluent ulcers with a whitish base and a thin band of surrounding erythema. Two small ulcers were noted in the gastric antrum. *Helicobacter pylori* urease assays of antral biopsies were negative. Histologic examination of biopsies of the distal esophagus demonstrated only necrotic debris. Syncytial cells or intranuclear viral inclusion bodies were not observed.

On the fifth hospital day, the patient's gums became swollen and bled easily. His hemoglobin was 11.9 g/dL and WBC was 7,600 with 57% segs, 29% lymphs, and 13% monocytes. The next day, he developed shallow necrotic lip ulcers. A Tzanck preparation of these lesions was negative. He became afebrile but continued to vomit and complain of severe abdominal pain.

On the seventh hospital day herpes simplex virus type 1 (HSV-1) grew from his esophageal biopsies. Intravenous acyclovir (40 mg/kg/day divided every 8 hours) therapy was instituted. Within 24 hours, the vomiting stopped and epigastric pain diminished. The next day, he was able to drink and eat a soft diet. Five days of intravenous acyclovir and 5 days of oral acyclovir were given. No other family members developed herpetic lesions and the patient denied previous herpetic infections.

Immune evaluation revealed a negative HIV titer, normal serum levels of immunoglobulins, a normal T_4/T_8 lymphocyte ratio, normal distribution of T cell subsets, and a normal response of the patient's lymphocytes to a variety of antigens and mitogens.

Discussion

Only seven cases of herpetic esophagitis in immunocompetent children have been previously reported in the English language medical literature.[1,10-12] Bastian and Kaufman described a 10-year-old with fever, substernal pain, and inability to eat, who, like our patient, grew HSV-1 virus from esophageal lesions.[10] Moore et al reported a 6-year-old boy with cystic fibrosis and similar symptoms who grew HSV-1 from esophageal ulcers and a 2-year-old girl with inability to swallow who was diagnosed as having herpetic esophagitis on the basis of culture of the virus from esophageal lesions.[11] Nash and Rost briefly mentioned a 4-year-old girl with burns and herpetic pneumonia who demonstrated esophageal changes consistent with herpetic esophagitis.[1] Ashenburg et al described three apparently normal children, aged 14 years, 17 years,

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The authors are with the Department of Pediatrics at the Children's Hospital of Wisconsin in Milwaukee: Dr Chusid in the Division of Infectious Diseases; Dr Oechler in the Division of Pediatric Pathology; and Dr Werlin in the Division of Gastroenterology. Reprint request to: Michael J. Chusid, MD, Department of Pediatrics, MACC Fund Research Center, Medical College of Wisconsin, 8701 Watertown Plank Rd, Milwaukee, WI 53226. Copyright 1992 by the State Medical Society of Wisconsin.

Continued from preceding page
and 11 months, who grew herpes simplex virus from esophageal ulcers.[12] These children had odynophagia, nausea, vomiting, and substernal pain as their most prominent complaints.

Significant gastrointestinal bleeding has been previously noted in adult, but not pediatric patients, with herpetic esophagitis.[6,8] Our patient, unlike the previously reported children, also demonstrated significant hematemesis. In fact, his admitting diagnosis was hematemesis, thought due to a Mallory Weiss tear of his esophagus.

The diagnosis of herpetic esophagitis should be suspected in the proper clinical situation, such as a patient with unexplained substernal pain and odynophagia. Radiography may be of use in diagnosing the condition. Double contrast esophagrams show characteristic ulcerations, particularly of the distal esophagus.[2,9] Definitive diagnosis, however, requires esophagoscopy. Typically, herpetic lesions appear as punched out ulcers in the esophageal mucosa.[9] Frequently, the ulcers have heaped-up borders which are described as "volcano" lesions.[9] Diagnosis can be made histologically by the demonstration of Cowdry type A intranuclear inclusions within macrophages from the base of the ulcers or by the presence of giant syncytial (Tzanck) cells. In fact, these histologic findings were not noted in our patient, nor in many of the previously reported children with herpetic esophagitis.[10,11] Culture of herpes simplex virus from esophageal lesions therefore remains the most definitive diagnostic technique available. In some instances, viral particles have been demonstrated within infected cells from ulcer bases by electron microscopy.[4]

Treatment of herpetic esophagitis can be difficult. Orally administered topical analgesics such as viscous xylocaine are generally ineffective in decreasing symptomatology. In immunocompetent adults, supportive therapy alone is considered adequate since the infection is usually self limited. In immunocompromised patients or severely affected immunocompetent patients, however, acyclovir therapy has been employed.[3,8] Although our patient was likely nearing that end of the course of his disease, the decrease in his symptomatology, concurrent with the institution of acyclovir therapy was remarkable.

Herpes simplex esophagitis remains an unusual infection in children, but probably occurs more often than it is currently recognized. In the proper clinical setting, with the appropriate physical findings, this disease entity needs to be considered, even in an immunocompetent patient.

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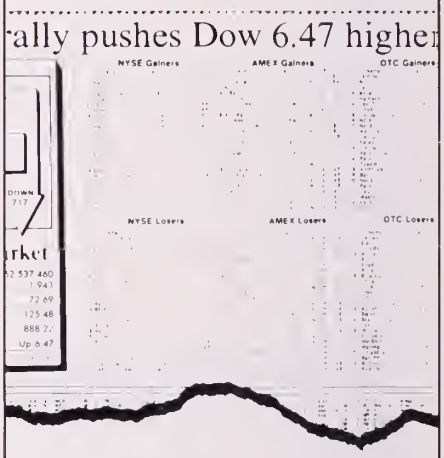

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Special

Physicians, pinstripes, and prevention: Wisconsin data

James E. Casanova, MD, and Rick D. Gillis, MD, Milwaukee

To ward off disease or recover health, men as a rule find it easier to depend on the healers than to attempt the more difficult task of living wisely. -Rene Dubos

HEALTH MAINTENANCE and prevention are subjects that have, perhaps, traditionally received inadequate attention in medical education and the practice of medicine. Now, these concerns have become cornerstones of a renewed effort to improve upon the health of Americans. Especially attractive at this time is that by focusing on personal lifestyle issues health status can often be improved without the use of complicated technology and major financial expenditures. The US Department of Health and Human Services (DHHS) initiated the "Healthy People 2000" program that set forth national goals for health promotion. (Wisconsin has initiated a complementary program titled "Healthier People in Wisconsin.") As noted by DHHS Director Louis Sullivan, MD: better control of fewer than 10 risk factors–such as poor diet, lack of prenatal care, infrequent exercise, use of tobacco, alcohol and drug abuse, and the failure to use seat belts–could prevent between 40% and 70% of all premature deaths, a third of all cases of acute disability, and two thirds of all cases of chronic disability.[1]

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In addition, the US Preventive Services Task Force has recently published guidelines for routine health care that focus very strongly on counseling and lifestyle modification.[2] Despite these recommendations, physicians face a dilemma: either suffer professional and public criticism for inattention to preventive health care or attempt to provide such services in the face of powerful impediments.[3]

Problems encountered in pursuing these goals include lack of time, patient disinterest, lack of immediate gratification and poor compensation for these efforts (witness the recent battle over the RBRVS conversion factor). One additional factor in this scenario is the physician's personal health habits. The literature shows that physicians' health habits have a direct effect on their willingness and ability to successfully counsel patients. How are physicians and their patients doing on this subject?

Wisconsin data[4] show much room for improvement in the general population. Twenty-six percent of the population smokes, 27% is overweight, 58% lives a sedentary lifestyle, 28% does not use seat belts. In addition, Wisconsin ranks second for state incidence of driving while intoxicated.

In addition to the above data, we collected lifestyle information from the Medical College of Wisconsin's Executive Physical Program. We postulated that this group of upper-level executives, well-educated and highly motivated, would surely be leaders in incorporating these recommendations into their daily lives. Data from a random sample (n=100) of participants in this program was analyzed and is presented in the table.

Finally, we sought to determine how physicians were doing in this regard. As part of a Medical College of Wisconsin Continuing Medical Education course held for primary care physicians in September 1991, we surveyed participants (n=130) concerning their personal health habits. To add "zest" to otherwise plain statistics we present this physician data, along with the executives' data, in Table 1 as a form of friendly competition.

In addition, we asked physicians about three other aspects of their health care: 95% had a blood pressure check in the previous 2 years; 91% had a cholesterol check in the previous 5 years; 55% have a personal physician.

Personal health habits: a comparison of executives and physicians.

	Executives	Physicians
Seat belts not used	28%	8%
Diet not balanced	48%	28%
Use of cigarettes	24%	3%
Regular alcohol use	86%	38%
Sedentery lifestyle*	78%	51%
Excess stress at home	28%	17%
Excess stress at work	16%	53%

*Less than 30 minutes of exercise 3 times per week.

How are we physicians doing? We may gloat in our "victory" or note that there is much room for improvement. This study, of course, cannot claim to have a rigorous scientific design and the results may be questioned. Nevertheless, we find this data interesting on both a professional and personal level. The most telling statistic may be the amount of "excess stress at work."

We leave further conclusions up to the reader. Suffice it to say that physicians' health, physical and mental, is certainly closely intertwined with our ability to function successfully-both personally and professionally. As we take good care of our patients, we need to be reminded to also take good care of ourselves.

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The Americans with Disabilities Act

Sally Wencel, JD, SMS assistant corporate counsel

The Americans with Disabilities Act (ADA) was enacted July 26, 1990. The ADA's primary purpose is to create enforceable standards addressing discrimination against individuals with disabilities and to ensure that the federal government plays a central role in enforcing these standards for individuals with disabilities. The ADA contains four titles, addressing employment, public services, public accommodations by private entities, and telecommunications. Clinics employing more than 15 persons, HMOs and other managed care organizations are subject to both the employment and public accommodation provisions of the ADA and will need to assure they are in compliance with its requirements as the law goes into effect.

Most public accommodation obligations are now applicable to clinics, HMOs and other health care facilities that serve Medicaid and Medicare patients and employ more than 15 persons or have federal grants, loans, and contracts under the Rehabilitation Act of 1973. The primary effect of the Americans with Disabilities Act is to expand the nondiscrimination requirements under the Rehabilitation Act of 1973 to all private employers with more than 15 employees and to private organizations that provide public accommodations, including physicians' offices.

This article reviews the ADA's basic requirements concerning employment and public accommodations and services operated by private entities, Title I and Title III of the ADA, as well as the federal rules. Existing Wisconsin law, which is enforceable if more strict than federal law, is also discussed.

Title I

Employment

Under the ADA, employers may not discriminate against qualified individuals with disabilities. The federal Equal Employment Opportunities Commission (EEOC) will administer the ADA and has promulgated regulations to give the employment section of the ADA effect. In addition to the regulations, the EEOC issued interpretive guidelines to aid employers to understand the ADA's requirements. The EEOC may order employers to reinstate, hire or promote the disabled person, pay back pay, and provide reasonable accommodations. In addition to filing a complaint with the EEOC, disabled individuals may also bring private discrimination suits. Despite the EEOC's enforcement of the ADA, many predict that Wisconsin's Department of Industry, Labor and Human Relations' Equal Rights Division (ERD) will provide the bulk of disability discrimination enforcement.

The EEOC requires covered employers to have a recruitment system that reaches disabled persons, have an accessible job application process, evaluate disabled persons based on their qualifications, make sure disabled employees are not routinely steered into low-level jobs or a particular job category, and avoid assuming a person cannot perform a certain job because of a disability. Additionally, the employer must be willing to make reasonable accommodations so that a disabled employee can perform the essential functions of his or her job. Accommodations include making the facility accessible through ramps and specially designed lavatories, job restructuring, offering part-time or flexible work schedules, equipment modifications or special devices such as changing office furniture, or providing readers and interpreters. The accommodations must be reasonable–there is an exception for accommodations that would pose an undue hardship due to the nature, cost, size of the facility, and type of operation.

The ADA employment standards go into effect for employers of 25 or more employees July 26, 1992, and for employers of 15 employees or more July 26, 1994. Effective Nov 1, 1991, the EEOC will provide information to callers on its toll-free line: (800) 669-EEOC.

The law before ADA

In Wisconsin, employment discrimination against the handicapped is already prohibited by the Wisconsin Fair Employment Act (Wis Stat §§111.321, 111.322 and 111.34). State

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law defines "handicapped individual" as an individual who: 1) has a physical or mental impairment which makes achievement unusually difficult or limits the capacity to work; 2) has a records of such an impairment; or 3) is perceived as having such an impairment. Discrimination against handicapped individuals is prohibited in hiring, termination, promotion, compensation, or terms, conditions or privileges of employment. Wisconsin law provides a private right to bring a discrimination charge against a discriminating employer before the ERD of the Department of Industry, Labor and Human Relations. Remedies for employment discrimination include back pay, instatement or reinstatement orders, costs and reasonable attorney fees.

Federal law through the Rehabilitation Act of 1973 provides that employees of every federal contractor having contracts of $2,500 or more are protected from handicap discrimination. The law prohibits discrimination based upon a "disability" in hiring, termination, promotion, compensation and other terms, conditions or privileges of employment. The Rehabilitation Act was considered limited in that it did not appear to provide a private right of action by an aggrieved private employee to sue a discriminating employer.

The problems that Congress attempted to address in enacting the ADA was the lack of uniform state laws prohibiting handicap employment discrimination, the limited scope (federal contractors) and the lack of a private right of action. Congress found that 43,000,000 Americans have one or more physical or mental disabilities, a number increasing as the nation's population ages. The ADA expanded the Rehabilitation Act's coverage to include all employers of a certain size, employment agencies, labor organizations, and joint labor-management committees.

Who is covered?

Title I of the ADA protects "qualified individuals with a disability" applying for a job or seeking a promotion. A "qualified individual with a disability" means an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the job in question.

To be "disabled" under federal law, an individual must satisfy one of three tests: the individual must 1) have a physical or mental impairment that substantially limits one or more of that person's major life activities; 2) have a record of such impairment; or 3) be perceived as having such an impairment. This federal definition is nearly the same as the state definition of disability so that most persons meeting one definition would also meet the other.

Physical or mental impairment includes any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the body systems or any mental or psychological disorder. A person's disability is not removed merely because its existence is mitigated by prosthetic devices or controlled through medicines. For example, a person with epilepsy is still considered disabled even if the epilepsy has been successfully controlled by a pharmaceutical regimen. Physical or mental impairment does not include physical characteristics, common personality traits, advanced age or environmental, cultural or economic disadvantages. For example, a person unable to read because he or she was never taught would not be disabled, but a person who is unable to read because he or she suffers from dyslexia is disabled.

A "major life activity" includes basic activities the average person and the general population can perform with little or no difficulty, such as caring for oneself, performing manual tasks, walking, seeing, breathing, learning, and working. "Substantially limits" can include not just whether a person can perform a major life activity but if the person cannot sustain this activity for the same duration as the average person in the general population.

The EEOC's interpretive guidelines provide a list of commonly disabling impairments, including substantial orthopedic, visual, speech and hearing impairments, HIV infection, AIDS, cerebral palsy, tuberculosis, multiple sclerosis, epilepsy, muscular dystrophies, cancers, heart disease, diabetes, mental retardation, and emotional and mental illness. The EEOC's guidelines also define those conditions not covered by the ADA–temporary non-chronic impairments of short duration, with little or no long term or permanent effect. Examples of temporary, non-permanent disabilities include broken limbs, sprained joints, concussions, appendicitis, and influenza. Obesity with few exceptions is not considered a disability. The ADA excludes as a disability transvestism, pedophilia, transsexualism, homosexuality or bisexuality, compulsive gambling, kleptomania, pyromania, exhibitionism, or psychosis resulting from current illegal drug abuse.

"Employer" is defined as "a person engaged in an industry affecting commerce who has 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, and any agent of such person." The ADA allows for a transition period–for the first

The Americans with Disabilities Act was passed by Congress to assure disabled persons full access to the range of employment opportunities, public transportation and communication services, and public accommodations enjoyed by the general population. In so doing, Congress and the agencies responsible for administering the law created an elaborate and arguable unduly complex set of standards. Perhaps due to the delayed effective date, there has been surprisingly little comment on the effect this law will have on the health care industry. As more information becomes available, the SMS, AMA and various specialty societies will provide more guidance.

2 years following the ADA's effective date the number of employees is 25 rather than 15. The ADA further exempts the United States, a corporation wholly owned by the United States, an indian tribe and bona fide membership clubs exempt from taxation under §501(c)(3) of the Internal Revenue Code of 1986.

Discrimination defined

The ADA prohibits discrimination against a qualified disabled individual because of the disability or perceived disability in job application procedures, hiring, advancement and discharge, and terms and conditions of employment, including compensation, advancement and job training. Discrimination is defined in the following ways:

- limiting, segregating or classifying a job applicant or employee in a way that adversely affects the opportunities or status of the applicant or employee because of his or her disability;
- participating in a contractual or other arrangement or relationship that has the effect of subjecting a qualified applicant or employee to prohibited discrimination (examples of these arrangements are employment or referral agency, unions, an organization providing fringe benefits, or an organization providing training and apprenticeship programs);
- using standards, criteria, or methods of administration that have the effect of discrimination on the basis of disability or perpetuate the discrimination of others who are subject to common administrative control;
- excluding or otherwise denying equal jobs or benefits to a qualified individual because of the known disability of the individual with whom the qualified individual is known to have a relationship or association;
- not making reasonable accommodations to the known physical or mental limitations of an otherwise qualified disabled individual who is an applicant or employee, unless the employer can show the accommodation would "impose an undue hardship" on the operation of its business;
- denying employment opportunities to a job applicant or employee who is otherwise qualified if the denial is based on the need to make reasonable accommodations;
- using qualification standards, employment tests or other selection criteria that screen out or tend to screen out the disabled unless the standard, test or other selection criteria is shown to be job-related for the position in question and is consistent with business necessity; and
- failing to select and administer employment tests in the most effective manner to ensure that results accurately reflect skills, aptitude or other factors the tests purport to measure rather than reflecting the applicants or employee's impaired sensory, manual or speaking skills, except when these skills are the factors the tests purport to measure.

Despite the broad definition of discrimination, an employer is free to select the most qualified applicant available and to make decisions based on reasons unrelated to the existence or consequence of a disability.

Particularly important to medical offices and health care institutions, the ADA allows using the qualification standard that the individual not pose a direct threat to the health or safety of other individuals in the work place. This threat must be substantial–there must be a high probability of substantial harm to the individual or others. If the otherwise qualified individual poses a direct threat as a result of his or her disability, however, the employer must still determine whether a reasonable accommodation would either eliminate the risk or reduce it to an acceptable level. If no such reasonable accommodation exists, the employer may discharge an employee or refuse to hire an applicant who poses a direct threat. The EEOC regulations further state the assessment must be individualized, based on reasonable judgment that relies on current medical knowledge or the best available objective evidence to ascertain: 1) the nature, duration and severity of risk; 2) the probability that potential injury will actually occur; and 3) whether reasonable modifications of policies, practices, or procedures will mitigate the risk.

Undue hardship and reasonable accommodation

The terms "reasonable accommodation" and "undue hardship" are critical to understanding employer obligations under the ADA. First, an employer need only reasonably accommodate those disabled individuals who satisfy the skill, experience, education and other job-related selection criteria set by the employer. If applicant can perform essential functions of the job with reasonable accommodations, the applicant is considered "otherwise qualified" for the job. An individual who can perform those essential functions, with or without accommodation, is qualified even if they cannot perform the job's peripheral or marginal functions. "Reasonable accommodation" is defined to include making existing facilities used by employees readily accessible to and usable by disabled individuals, job restructuring, part-time or modified work schedules, re-assignment to vacant positions, acquisitions or modification of equipment or devices, changing training materials or policies, providing qualified readers or interpreters, and "other similar accommodations." Finally, the employer is only required to accommodate known impairments.

Employers are released from this obligation to provide reasonable accommodations if it would pose an undue hardship. The ADA defines undue hardship to mean imposing significant difficulty or expense when considering several factors. These factors include: 1) the nature and cost of the needed accommodation; 2) the overall financial resources of the facility and the overall effect on expenses and resources to make the accommodation; 3) the overall size of the business considering the number of employees; 4) the

Continued on page 79

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Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported, it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated, however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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Continued from page 77

number, type and location of facilities; and 5) the type of operation–including the composition, structure, and functions of the work force, the geographic separateness, administrative and fiscal relationship of the facilities with the employer, and the effect of the accommodation on operating the site, and its effect on the ability of other employees to perform their duties and the ability of the facility to conduct business. In total, undue hardship relates not just to financial difficulty but also to how substantial and disruptive the accommodation may be to the nature and operation of the business.

Current illegal drug use

The ADA does not protect employees or applicants who are now engaged in the illegal use of drugs when this drug usage is the basis for the employer's actions. Illegal use of drugs is defined by the ADA to mean the unlawful use, possession or distribution as defined by the Controlled Substances Act, but does not include the use of drugs taken under the supervision of a licensed health care professional or other uses permitted by federal law. The ADA does, however, protect qualified individuals who have successfully completed or are currently participating in a supervised drug rehabilitation program and no longer engage in illegal drug use. The ADA also explicitly authorizes employers to prohibit drug or alcohol use by employees at the work place and require employees to comply with the Drug-Free Workplace Act of 1988. Moreover, the ADA states that drug tests are not considered medical examinations (as discussed below).

Defenses to discrimination

Employers may defend otherwise discriminatory actions if the selection criteria that screen out, tend to screen out, or deny promotion of disabled individuals are shown to be job-related and consistent with business necessity. Moreover, the employer must show that it can not reasonably accommodate for the disability. Religious entities are not prohibited from giving preference in employment to individuals of a particular religion to perform work connected with its functions. Also, a religious organization may require all applicants and employees to conform to its religious tenets. This allows private health care institutions with religious affiliations to discriminate in favor of hiring and promoting persons of that religion and to impose certain restrictions on practices or acts that violate the tenets of that faith.

Medical examinations and inquiries

The ADA prohibits employers from using medical examinations and inquiries during the screening process with a few exceptions. Employers may not conduct medical examination or inquire into whether an applicant is disabled and the extent of the disability unless this examination or inquiry is job-related and consistent with business necessity, or the

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employee volunteers to the medical examination as part of an employee health program. Examinations commonly conducted to determine whether an employee or applicant is qualified under this job-related or business necessity exemption are commonly referred to as "fitness for duty" examinations. Examples of these permitted examinations include those required of airline pilots, police officers, or fire fighters where performance of specific physical or sensory standards are essential. The other exception to this bar against pre-employment medical examination is where this testing is required by law, such as Federal Aviation Administration regulations mandating periodic examinations of pilots.

An employer may, however, require a medical examination after offering the job to an applicant and before starting employment duties if two requirements are met. First, the employer must require that all entering employees undergo the medical examination. The examination itself does not need to be limited to inquiries about the applicant's ability to perform the job's essential functions. For example, the employer may conduct voluntary medical examinations as part of an employee health program. Some health insurance carriers offer group health discount rates to employers that conduct employee health and lifestyle screening. The employer, however, may not take back the job offer based upon medical information obtained through the examination unless the applicant or employee failed to meet job-related criteria.

The second requirement for using medical examination is that the information obtained about the person's history or current health status must be kept confidential. This medical record information must be maintained on separate forms and in separate medical files. The ADA restricts work access to this information to supervisors or managers who need to be informed of work restrictions or necessary accommodations or to first aid and safety personnel in the case of a medical emergency. The EEOC officials may have access to medical files to investigate compliance with the ADA.

As discussed previously, testing for current use of illegal drugs is not a medical examination under this law. The EEOC interpretative guidelines state, however, if the drug testing results reveal information about an individual's medical condition beyond whether he or she is currently engaged in the illegal use of drugs, this additional information is treated as a confidential medical record.

Also, the ADA's confidentiality requirements concerning medical examinations do not pre-empt state health care records and mental health records laws concerning access and confidentiality.

Compliance with ADA

All employers covered by the ADA may need to make certain changes in their hiring, promotion, and termination policies, or when asked to make accommodations for current employees. Employers may also need to expand affirmative action activities to invite disabled persons to apply for positions.

With hiring, the employer should first design written job descriptions that clearly state the essential functions of the job. As discussed previously, the ADA only protects disabled persons who are qualified to perform the job's essential functions, with or without reasonable accommodations. (The disabled individual need not be able to perform peripheral or marginal functions to be qualified.) The ADA provides that, if prepared before advertising and interviewing, written job descriptions that include essential functions shall be considered evidence of the essential functions of the job. The job description must truly reflect the position and its requirements. The EEOC's initial inquiry into possible discrimination will be whether other individuals in the same job are required to perform the functions claimed to be essential. Also reviewed will be whether the reason for the position's existence is to perform that function, the number of other employees available to perform that function, whether other employees have that skill, and the time spent performing the function.

Employers must also clearly articulate qualification standards, both in the job description and when advertising available positions. Job qualification standards should include both mental and physical standards necessary to perform the essential functions. The requirement that the employee not pose a direct threat to the health and safety of himself or herself or others may be specifically listed as a qualification standard for the position. It is also important for employers to document qualification standards since employers may test applicants or make pre-employment inquiries into the applicant's ability to perform these job-related skills, with or without accommodation. Again, in no case may employers ask for information on the application form about possible disabling conditions unless the applicant volunteers the information as part of the employer's affirmative action plan.

Employers, particularly those whose operations require physical labor, may find it best to use experts in occupational medicine or industrial engineering to do job analyses to define the physical qualifications required to perform the job's essential functions. This expert advise helps to show the EEOC the employer's otherwise discriminatory criteria are legitimately job-related and a matter of business necessity.

If using post-hire medical examinations, an employer must be careful to require all persons in the same job class to submit to the examination. As discussed previously, an employer may withdraw the employment offer based on an examination result if it reveals a condition or disability that relates to the job applicant's ability to perform the essential job functions or if it poses a direct threat. As mentioned earlier, employers may discriminate if the applicant tests positive for an infectious disease, if the job would place the applicant in the position of transmitting the disease to others

Continued on page 82

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and there is no reasonable means to prevent this risk. Also, employers may require employees to submit to alcohol or drug screening test as permitted by state law. (Currently, there is no Wisconsin statute regulating drug testing in the workplace.) Please note, however, the ADA only allows discrimination in hiring, promoting, or firing persons who currently use illegal drugs. The ADA protects employees suffering from alcoholism, or are recovering from past drug or alcohol abuse and testing is limited to ascertaining whether the employee is in compliance with rehabilitation for that addictive or abusive disorder.

The ADA's most difficult requirement for employers to meet may be providing "reasonable accommodations" to otherwise qualified disabled persons. The law defines several ways an employer is expected to accommodate an employee or applicant with a known disability. One common example is job restructuring, where the employer must reassign to other employees those marginal or peripheral tasks the disabled person is unable to perform, even if this assignment reduces efficiency, unless it would pose an undue hardship. The EEOC may expect an employer to change the facilities to make them readily accessible to disabled employees. An employer may need to change both the physical features of the work place as well as equipment used by disabled employees. These changes may already be required by Title III as discussed later in this article. If the disabled individual's work hours are limited by problems created by public transportation, the employer may be expected to modify the employee's work schedule. Finally, the law may require the employer to offer to transfer the disabled employee to a vacant position if the employee is unable to perform the job's essential functions after trying to resolve the problem through other reasonable accommodations.

Employers should remember two critical aspects to this reasonable accommodation requirement–the requirement applies only to "known disabilities" and need not be the best accommodation under the circumstances. The employee is responsible for requesting the accommodation. Employers do not need to provide an accommodation to a disabled person who has not requested it, particularly if providing this accommodation focuses attention on a disability the employee did not want revealed to others. The law gives no guidance to an employer when the employee's disability affects his or her job performance but has not requested an accommodation.

The law does not require the employer to make the most extensive or expensive modifications or accommodations, only those that are "reasonable" and meet the needs of the accommodated person. In fact, the EEOC regulations state that an otherwise qualified disabled individual is no longer protected by the law if the employer offers a reasonable accommodation which the employee chooses not to accept and, as a result of that rejection, the individual is unable to perform the essential functions of the job. Ideally, the employer will consult with the disabled employee to check the employee's preferences and determine the most appropriate accommodation for both the employer and employee.

An employer must carefully document the decision against making an accommodation for a qualified disabled person for undue hardship reasons. The employer carries the burden of proving this decision is proper, requiring proof of the significant difficulty or expense. For example, the employer may be required to show the accommodation's cost is undue when compared to its budget and that alternate fund sources are not available. Costs are not the only consideration–the employer may prove undue hardship by showing that the accommodation would be unduly disruptive to the business or the functioning of other employees.

The ADA expressly states that nothing shall be construed to prohibit or restrict an insurer, hospital, or medical service company, HMO, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with state law. This provision is meant to allow medical underwriting in a manner permitted under state insurance laws. In other words, employers may limit health benefit coverage or enrollment into other benefits like life insurance as permitted by state law based on an employee's disability and commit what would otherwise be described as discrimination. This allowance applies to employers offering benefits under a self-funded plan as well as those offered through insurance carriers.

The EEOC interpretative guidelines state the ADA allows employers to continue developing and administering benefit plans according to accepted risk assessment principles so long as these restrictions are not intended to evade the purposes of the law. For example, employers may continue offering health insurance that excludes treatment for preexisting conditions although this may adversely affect a disabled employee. An employer may offer health insurance that limits the number of medical treatments during the policy year or set a lifetime ceiling on payment for certain disorders despite its disparate affect on persons with disabilities. To use the example given in the interpretative comments, an employer may limit the number of blood transfusions covered by health insurance to 5 a year and not be discriminatory although it would adversely affect hemophiliacs. An employer, however, may not deny a qualified disabled individual equal access to insurance or subject him or her to different terms or conditions based on the disability alone if the disability does not pose increased risks. This area of the ADA may be a source of vigorous litigation as employers try to limit their health care benefit expenses.

Physicians and clinics

Physicians who qualify as employers through the size of the office or clinic's work force should consider the ADA's prohibitions. This count includes non-physician employees and physicians if otherwise considered an employee. Most physicians practicing in a service corporation act both

shareholders and employees and would therefore be included. Truly independent contractors need not be counted when determining whether the federal law's threshold has been reached.

Clinics may refuse to hire or promote disabled employees to positions that would endanger to the health and welfare of its patients or other employees–the "direct threat" qualification standard allowed by the ADA. As one example, whether a health care provider may refuse to hire or promote an HIV or hepatitis B positive applicant or employee depends on if there would be a significant risk of transmitting the infection to others and if no reasonable accommodation can be made to eliminate the risk. These standards are true of any infectious or communicable disease with which an employee or applicant may be infected.

The Center for Disease Control recently released guidelines distinguish risk of transmission by health care workers based on whether they perform "exposure-prone procedures." (This term is defined as those procedures in which the worker might be cut or injured and his or her blood contact a patient's body cavity, subcutaneous tissues or mucous membranes.) The CDC recommends health care workers performing exposure-prone procedures should find out their HIV and hepatitis B status. Offices and clinics will need to follow these epidemiologic developments to determine whether their conduct will be considered lawful under the ADA. Regardless of the nature of the risk, the clinic or office should carefully document the decision and outline the medical reasons for this permitted discrimination.

The law does not address the means by which an employer may determine an employee's HIV status or other infectious disease status except under the general medical examination regulations. It is possible that testing health care providers, as employees, for HIV status is allowed if the risk of transmission is scientifically founded and not controllable through reasonable measures and if all similarly classified employees are subjected to this pre-employment testing.

Another consideration for physician employers is the ADA's exclusion of current illegal use of controlled substances as a disability. A physician or clinic may refuse to hire an employee based upon a positive drug screen. The ADA protects alcoholics and recovering drug abusers to the same extent as other disabled persons, however, and care should be taken when receiving an application for employment or when dealing with a recovering employee. Medical offices and clinics may require periodic drug or alcohol screens and prohibit or impose restrictions on cigarette smoking. Employers may also periodically test an employee undergoing drug or alcohol rehabilitation to assure the employee is following the treatment program. Again, in some instances the direct threat issue may arise with employees with a history of alcohol or drug abuse although a clinic or physician employer covered by the ADA must make an individualized assessment based on a valid medical analysis to determine whether the individual poses a high probability of substantial harm to himself or herself or others.

In some instances, physicians may be considered acting as an employer's agent when providing medical services to employers under contract or through other arrangements. Even if a medical office does not meet the ADA's 15 employee threshold, actions by physicians and others may be subject to EEOC scrutiny. The actions of physicians in this instance will be imputed upon the employer, including employment discrimination by the medical office, improper inquiries in employment screening medical examinations, and complying with medical record confidentiality requirements. As stated earlier, the medical record confidentiality requirements are generally less strict than current Wisconsin medical record laws, and the ADA's effect is minimal. The actual effect of the other aspects concerning improper inquiries into disabilities and medical office employment practices, however, is not so clear. It is possible, for example, for the EEOC to investigate clinic office records to determine the existence and extent of discrimination by an employer based upon a complaint brought by a disabled employee or job applicant who was examined by a clinic physician. Under these circumstances, the EEOC is entitled to access to the records.

As with any new law, there remains many unanswered questions about the ADA's application to specific incidences. One issue for medical offices is whether the ADA is intended to prohibit physician and other health care provider credentialing inquiries that require disclosure of a variety of possible disabilities. In addition to the impairment issue, most credentialing forms being adopted by clinics follow the medical staff application forms that require disclosure of past and present mental and physical history. Most likely, this line of questioning may be acceptable under the essential functions and direct public threat tests permitted by the law. Clinics performing this level of applicant review should document the reasons for inquiries of this nature. At best, the EEOC will offer future advice that addresses these specific problems where the ADA clashes with other legal requirements and responsibilities.

Title III

Public accommodations and private enterprises

Under this section, private entities providing public accommodations are required to make commercial premises and services more accessible to disabled persons by removing physical barriers, providing disabled persons "auxiliary aids" and making the facilities otherwise "readily accessible." The ADA also prohibits discrimination of the disabled through policies, practices and procedures. More than perhaps any of the ADA's other provisions, the public accommodations provisions drew heated debate and comment by the many groups who are directly affected by its requirements. The penalties for failing to comply with these requirements are high–civil penalties ranging from $50,000 to $100,000 per

violations. The ADA allows disabled persons as well as the US attorney general to bring an action to enjoin violators.

As discussed previously, physicians should be aware of the ADA's requirements concerning public accommodations and services operated by private entities since many clinics will come under the law's purview. Many of the accommodations required under this law have been required of physician offices through section 504 of the Rehabilitation Act of 1973. Congress patterned the ADA's definitions and requirements after those of section 504. One problem with the Rehabilitation Act was the issue of whether certain private entities were covered because of their "accepting financial assistance." With health care providers, the government and advocates for the disabled argued that accepting Medicare and Medicaid reimbursement for services constituted accepting federal financial assistance and that hospitals, for one, were included. The ADA removes that ambiguity, since all private entities "having an effect on interstate commerce" providing public accommodations must comply with its provisions.

The public accommodations requirements do not relieve a private entity from its obligations under section 504 and federal regulations when the ADA's standards are lower. The EEOC retains its jurisdiction to pursue violations of section 504 of the Rehabilitation Act. Also unaffected are remedies provided by state statutes and tort law that may allow for punitive damages or other damages greater than those provided by the ADA.

Wisconsin law

Like employment discrimination, Wisconsin has a law that prohibits denying or limiting the use of and access to public accommodations on the basis of disability. Under Wisconsin law, hospitals and clinics are specifically included and medical offices likely to be included as public accommodations. State law does not go into the intricate detail of the ADA and its regulations and leaves enforcement to the ERD. Penalties for the first violation of this anti-discrimination law are a fine of not less than $100 nor more than $1,000. Subsequent violations within a 5-year period may result in a forfeiture of not less than $1,000 nor more than $10,000.

Federal law

Title III states that no individual shall be discriminated against because he or she is disabled in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases, or operates a place of public accommodation. Like the employment standards in Title I, this prohibition against discrimination extends to individuals with disabilities, individuals perceived to be disabled, and those who associate with disabled individuals. The ADA includes the professional office of a health care provider in the long list of public accommodations. The US attorney general is responsible for ensuring compliance with the ADA. Remedies for violations of these provisions include required compliance and possible civil penalties of up to $50,000 for the first violation and $100,000 for subsequent violations. The courts may consider good faith efforts or attempts to comply with the ADA when determining the amount of the penalty. This section goes into effect in early 1992.

Concerning physical structures, the ADA distinguishes between existing facilities, which need only be "readily accessible" if other alterations are made, and new facilities intended for first occupancy after January 1993. The new construction and upgrading of existing structure requirements are expansive. This article focuses on requirements for hospitals and private offices of physicians and other health care providers.

The Office of the Attorney General (OAG) has prepared a document entitled "ADA accessibility guidelines for buildings and facilities" (titled *Appendix A*) that provides a comprehensive review of technical requirements for new construction and alterations of existing public accommodations and facilities. A copy of this document and the federal regulations may be obtained by writing to the Office on the Americans with Disabilities Act, Civil Rights Division, US Department of Justice, PO Box 66118, Washington, DC, 20035-6118; or calling (202) 514-0301.

Who is covered?

Interstate commerce. As mentioned in the introduction, the ADA applies to private entities whose operations affect commerce between states or between a state and foreign country or territory. In the past, the issue whether private medical practice affects interstate commerce has been open to dispute in court, especially in physician peer review lawsuits. Last year, the US Supreme Court put the issue to rest by finding that one ophthalmologists hospital practice affected interstate commerce. The OAG's interpretative comments to the federal regulations further define commerce to include purchasing or selling products manufactured in other states or countries, or providing services to individuals from other states. The OAG also notes that because of the integrated nature of the national economy, the ADA and federal regulations will have extremely broad application. Under other traditional considerations, physicians who treat Medicare or Medicaid patients have been considered engaging in interstate commerce.

Public accommodations. In addition to affecting interstate commerce, the private entity must provide public accommodations. These public accommodations may also be considered "commercial facilities," a distinction important in reviewing whether new construction is required and will be discussed later. The ADA specifically includes the professional office of a health care provider and hospitals in the list of public accommodations. The requirements apply not only to the owners of the premises but to the lessors and

operators as well. The lease provisions apply to tenants as well as landlords if the tenant is engaged in commercial activities. Therefore, if a hospital leases office space to a medical practice, both the hospital and the medical practice are responsible for assuring that the office is accessible to the disabled.

Other public accommodations listed in the ADA include hotels, restaurants, bars, motion picture houses, theaters, auditoriums, convention centers, bakeries, laundromats, banks, zoos, museums, private schools, health spas, golf courses, and other places of recreation.

As with the Title I employment provisions, the ADA's coverage does not extend to private clubs or religious organizations or entities controlled by religious organizations, including places of worship. The act also covers private residential facilities used for public purposes or leased or rented residences, but does not include areas which are exclusively used as private residences.

The OAG's interpretative comments shed light on the potential lyexpansive nature of the ADA's coverage. In some instances, entities not covered become covered because they engage in certain activities. As one example, private entities which do not otherwise offer public accommodations may be required to comply with the ADA if they lease or rent space from a public accommodation. The interpretative comments use the example of a trade association or performing artist renting space for a conference or performance. The association, for example, would be required to abide by the ADA and regulations concerning providing such things as interpreters, braille programs, for the conference participants.

Private residences may become public accommodations for the purposes of the ADA if part or all of the residence is used to operate a business. For example, the part of a private home used during the day as a day care center is subject to the public accommodation requirements of the ADA. Another example is if a physician uses part of his or her private residence as his or her private office, that part of the house would be subject to the ADA's public accommodations requirements.

The ADA does not apply to those public facilities under other law, such as railroad cars, locomotives, stations and right-of-ways, or facilities otherwise covered by other parts of the ADA (commercial and public transportation). Facilities covered or expressly exempt from the federal Fair Housing Act are also excluded.

Who is protected?

Title III's protection applies to the same class of individuals as Title I–persons who have a physical or mental impairment that substantial affects one or more major life activity, have a record of such impairment or are regarded as having an impairment. Persons who currently use controlled substances in an illegal manner are not protected but those who have a history of illegal drug use or are currently enrolled in a drug rehabilitation program are protected by the ADA. As mentioned earlier, the law also protects those who associate with disabled individuals. The regulations are similar to those of the EEOC in further defining what constitutes a disability.

Discrimination defined

As stated in the introduction, the ADA is intended to guarantee disabled persons full enjoyment of and access to public accommodations. The ADA does so by defining discrimination and providing penalties for private entities failing to provide accessible accommodations. Entities may be compelled to make changes to facilities to comply with the accessibility standards created by federal rules. The ADA generally defines discrimination as directly or through other arrangements denying, affording a lesser or providing a separate opportunity to the disabled to participate in or benefit from the goods, services, facilities, privileges, advantages or accommodations. The ADA emphasizes that goods, services, facilities, privileges, advantages, and accommodations to the disabled be appropriately integrated. This prohibition means, for example, it is improper for a restaurant to offer dining services to the disabled in a separate section of the restaurant. The rules allow, however, separate benefits or services only when necessary to provide disabled persons opportunities as effective as those provided to others. This exception allows for reserved parking stalls and designation of special restroom facilities.

Discrimination is further defined to include the following actions for its tendency to deny or limit a disabled individual's opportunity to enjoy goods, services, facilities, privileges, advantages, or accommodations:

- imposing or applying eligibility criteria that screen out or tend to screen out an individual with a disability unless the criteria can be shown to be necessary for the provision of the goods, services, facilities, privileges, advantages, or accommodations being offered;
- failing to make reasonable modifications in policies, practices or procedure unless the entity can demonstrate that making such modifications would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations;
- failing to take steps necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently from other individuals because of the absence of auxiliary aids and services, unless the entity can demonstrate that taking such steps would fundamentally alter the nature of the goods services, facility, privilege, advantage, or accommodation being offered or would result in an undue burden;
- failing to remove architectural and communication barriers structural in nature in existing facilities where such removal is readily achievable; and
- if the entity can demonstrate that the removal of a barrier is not readily achievable, failing to use alternate methods if such methods are readily achievable.

The OAG's rules interpret the ADA's prohibitions to outline the affirmative steps private entities must take to avoid discrimination as defined above.

Policies and procedures

As described above, a public accommodation must change policies, practices and procedures that might otherwise discriminate against disabled persons unless the entity can demonstrate that making these modifications will fundamentally alter the nature of the goods, services, facilities, advantages or accommodations. This does not require modifications to the legitimate specialization of service providers if the service provider refers the disabled person to another public accommodation in the same manner as it would for individuals who are not disabled.

The regulations specifically use the example of medical specialization and states physicians may refuse to treat certain patients if the patient seeks treatment for an injury or illness for which the physician does not specialize. The example given in interpretative comments accompanying the regulations use the example that a physician who specializes solely in burn treatments may refer a deaf person to another physician for treatment other than a burn injury. It would, however, be discrimination for a physician who treats burn injuries to refuse to treat an HIV infected person who seeks treatment for a burn injury.

An example of a policy that must be modified under the ADA is a ban on animals in a hospital. Under this requirement, a service animal like a guide dog, signal dog or any other animal individually trained to provide assistance to a disabled person must be permitted in the general and patient visitation areas during visiting hours.

Auxiliary aids

Perhaps the most onerous requirement of medical offices, the ADA ends any remaining issue whether physicians must provide "auxiliary aids" to disabled patients. The law states that public accommodations shall take those steps necessary to ensure that no disabled individual is excluded, denied services, segregated or otherwise treated differently because of the absence of auxiliary aids unless the public accommodation can demonstrate that taking those steps would fundamentally alter the nature of the goods, services, facilities, privileges, advantages or accommodations offered or would result in an undue burden.

Under the Rehabilitation Act, the issue has arisen whether physicians must provide, for example, interpreter services to any hearing impaired patient regardless of whether there had been any previous difficulty in communicating with that patient. The ADA answers this issue by requiring auxiliary aids, except when it would alter the service or pose a significant difficulty or expense. The rules state even if the provision of a particular auxiliary aid or service would fundamentally alter the good or service or be an undue burden, the public accommodation must provide an alternative, if one exists. Neither the ADA nor the rules, however, provide any guidance on what alternatives exists. Like with the other affirmative requirements, the public accommodation has the burden of demonstrating the undue burden of providing these accommodations.

The term "auxiliary aid" is defined in the ADA and regulations to include qualified interpreters, note-takers, written materials, telephone handset amplifiers, assistive listening devices and listening systems, telephones compatible with hearing aids, television decoders, TTDs for the hearing impaired. For the visually impaired, the rules list qualified readers, taped texts, audio recordings, braille materials, and large print materials. The rules do add, however, that public accommodations are not required to provide its customers or participants with individually prescribed devices like glasses, hearing aids or personal assistance in eating, toileting or dressing.

Architectural barriers

This grouping of requirements look at physical barriers to disabled individuals in existing and future places of public accommodation. This includes alterations and removal of barriers in existing facilities and accessibility requirements for new construction. Removal and alteration are required if "readily achievable," meaning easily accomplishable and able to be carried out without much difficulty or expense. To determine whether an action is readily achievable, the ADA allows entities to consider the nature and cost, the overall financial resources, the number of employees at the facility, the effect on expenses and resources, and the overall effect on the operation at that site, and entities with more than one facility may consider additional factors of geographic separateness, administrative relationship between the sites, to name a few.

These factors are quite similar to the Title I definition of "undue hardship" which an employer may use to document the reason for not providing reasonable accommodations to disabled employees. In fact, private entities can refuse to take readily achievable actions to make the public accommodation readily accessible by demonstrating the actions would be an undue burden. Like Title I undue hardship, the private entity must document and be prepared to demonstrate that the modifications are not readily achievable. Even with this description, "readily achievable," is not readily understandable. The OAG's regulations are intended to give more meaning to this requirement. Needless to say, the question of what is "readily achievable" as required by law will probably be left to the courts to decide.

As stated in the beginning of this section, the ADA distinguishes between structural requirements of new construction and requirements for existing facilities.

New construction. At the law's time of passage the most controversial provision in the law concerned new construction. The law defines as discrimination the failure to design and

construct facilities for first occupancy after Jan 26, 1993, that are "readily accessible" to and usable by the disabled except where the entity can demonstrate that it is structurally impracticable to meet the requirements set forth in the law and regulations. One requirement of special concern to physicians is that elevators must be provided in buildings housing health care provider offices or the office must be located on an accessible ground floor.

Building alterations. Alterations made to existing public accommodations or commercial facilities made after Jan 26, 1992, must ensure to the maximum extent feasible that areas altered are readily accessible to and usable by disabled persons. An alteration is defined as a change that affects or could affect the facility's usability. The regulations give several examples of alterations that trigger this requirement to assure accessibility: replacing a floor, relocating an electrical outlet, installing or replacing plumbing fixtures, replacing door hardware (door handles and hinges). Normal maintenance such as painting, re-roofing, asbestos removal are not alterations. Replacing existing plumbing parts, rewiring an existing electrical outlet, changing a furnace but in the same location are also not alterations because the changes do not affect usability.

Removal of barriers. Existing facilities are required to have architectural barriers, including communication barriers, removed where readily achievable. The rules provide a list of examples for barrier removal: installing ramps; making curb cuts in sidewalks and entrances; lowering shelves; rearranging tables, chairs, and vending machines; lowering telephones; adding raised letter markers on elevator control buttons; installing flashing alarm lights; widening doors; eliminating turnstiles; installing accessible door hardware; installing grab bars on toilet stalls and other specific alterations to lavatories; creating designated accessible parking spaces; removing high-pile, low-density carpeting; or modifying vehicle hand controls.

The rules assign a priority to barrier removal measures. The first priority listed is measures to provide access to the facility from public sidewalks, parking, or public transportation. These changes would include sidewalk cuts, widening designated parking staffs, and installing an entrance ramp. The second series of changes concern measures to provide access to restroom facilities where restrooms are used by the public on a "more than incidental basis." Suggested alterations listed in the rules include removing obstructing furniture and vending machines, widening doors and toilet stalls, installing grab bars and providing accessible signs. Third, a public accommodation must take measures to make goods and services more accessible–lowering shelves, adjusting display racks, widening doors and installing ramps. The last priority simply includes any other measure necessary to provide access to the goods, services, facilities, privileges, advantages or accommodations of a public accommodation.

The rules also list alternatives to removing architectural barriers when the public accommodation demonstrates barrier removal is not readily achievable, if the alternative methods are readily achievable. For example, employees may retrieve goods from inaccessible shelves for disabled customers or provide home delivery of items. The rules even suggest multi-screen cinemas which do not make all screens accessible rotate the film schedule to include accessible screens. The theatres must also provide reasonable public notice of the accessible film screenings.

Other considerations

Landlord and tenant

As mentioned earlier in this article, both the landlord and tenant have responsibilities for complying with the public accommodations requirements of the ADA. This responsibility is clearly drawn under the auxiliary aids rules. The tenant is expected to provide auxiliary aids within the place of public accommodation, the physician office suite for example, and the landlord is responsible for providing aids in the common areas.

Unless the lease contract specifies, the landlord is responsible for making readily achievable changes in common areas or modifying policies, practices or procedures applicable to all tenants to achieve compliance with the law. The regulations state that if the lease allows tenants to make alterations with the landlord's permission, it is the responsibility of the tenant to request permission to make modifications. If the modification is readily achievable for the tenant, the tenant is responsible for making the changes. If the modification is not readily achievable for the tenant, the landlord becomes responsible (assuming the landlord is better able to bear the costs of making the modifications).

The interpretative comments use the example of an office building containing a physician's office. Unless the office space is limited to the ground level, there must be an elevator. Both the landlord and the physician tenant are required to make readily achievable modifications, including this requirement for providing elevators.

Terminating patient relationships

Physicians need to be aware that refusing to treat persons who are otherwise considered disabled by this law may be subject to a discrimination charge under both the ADA and Wisconsin law. These laws prohibit discrimination in the denial of good or services to the disabled. As with any patient being terminated, physicians should scrupulously document the termination process and in this instance include reasons for the termination other than the presence or history of a disability or association with a disabled person. It may not be legal to refuse to treat disabled patients based on their need for auxiliary aids, unless the physician's office can prove that providing auxiliary aids would be an unduly burdensome or substantially change the nature of the medical services.[15,16]

Public health

Policy implications of increased heart disease mortality

Frank M. MacDonald, MD, Bayfield

Northern Wisconsin is thought of as a very healthful area, with opportunities for a year-round active life. It is surprising, therefore, to find that mortality rates due to heart disease in this region have been consistently higher compared with the rest of the state. This paper analyzes published public health mortality data in an attempt to begin to define the nature of this problem and suggest public health policy intiatives to address the problem.

Heart disease mortality rates were obtained from reports of age-standardized mortality rates (to the 1970 US census), published by the Wisconsin Division of Health's Center for Health Statistics.[1] Data from four reports (each of which covered a 3-year period, eg 1969-1971) were averaged to provide an estimate for the 12-year period from 1969-1981. Although mortality data have been published annually since 1981, the rates are not age-adjusted and are, therefore, of limited use for making geographic comparisons. Age-adjusted rates for the seven Health Service Areas (HSA) for 1969-1981 were compared to the statewide average mortality rates. Z-scores were used to test for statistical differences in rates.

Heart disease mortality rates show considerable geographic variation, with the highest rates in the counties in northern Wisconsin (Fig 1). The area of highest heart disease mortality is quite localized, with seven northern counties showing a weighted average of 15% excess in heart mortality when compared with overall Wisconsin rates. Figure 2 compares the age-specific heart disease mortality rates for each of the seven HSAs with the state as a whole. The Northwestern (NW) HSA shows the greatest excess of heart disease, with an average excess of 13% compared with the rest of the state ($p<0.05$). Although the greatest difference was among persons ages 55-64, all age groups showed an increased risk.

During the 12-year period under study, more than 8,000 deaths due to heart disease occurred in these northwestern counties (table). If this area had the same death rate as the state overall, approximately 1,000 fewer deaths would have occurred.

Comment

Several northern counties show excessive age-adjusted mortality rates due to heart disease. Most of these heart disease deaths were coded as due to coronary heart disease, suggesting that some of the well-known coronary disease risk factors (diet, hypertension, and inactivity) may be present to an unusual degree in this area. Smoking may be more common in this area, since lung cancer and emphysema death rates are also higher in these counties compared with the rest of the state.[2,3]

It is unlikely that differences in death certification account for the increased mortality rates in northern Wisconsin. A

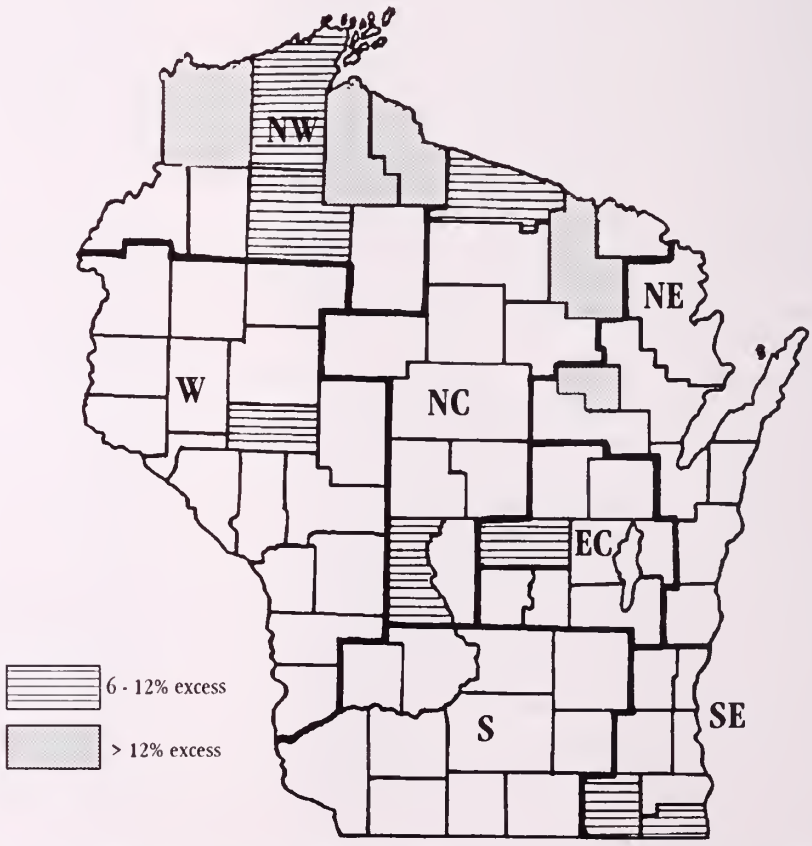

Fig 1.–Age-adjusted heart disease mortality rates by county, Wisconsin 1969-1981, expressed as relative differences between county and state rate. HSA are outlined.

Dr McDonald is a retired physician living in Bayfield. He practiced with the Pulmonary Disease Section of the Minneapolis VA Hospital and the faculty of the University of Minnesota Medical School. Reprint requests to Frank MacDonald, MD, Box 585, Bayfield, WI 54814.
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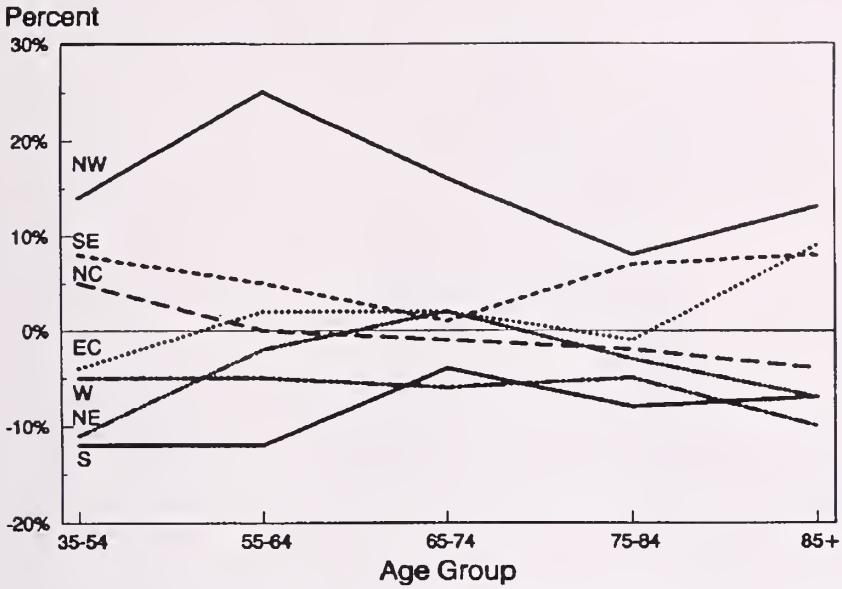

Fig 2.–Age-specific heart disease mortality rates by age and HSA, Wisconsin 1979-1981, expressed as relative differences between HSA and state rates.

higher proportion of deaths in the 8-county Northern HSA are certified by coroners than for the balance of the state. According to the Vital Statistics Section, however, there is little difference in the reporting of heart disease by coroner and non-coroner death certificates.

The rural character of this area alone is unlikely to explain the increased heart disease mortality rate, since many other similarly rural areas in Wisconsin have lower mortality rates. In addition, the northwest's most urban county (Douglas, with the city of Superior) has the highest heart mortality in the area. Finally, health problems of the relatively small (under 4%) Native American population of the area seem unlikely to explain the higher heart disease mortality rate, since US Indian Health Service has not found that death from heart disease is higher for the Native American population than for the general population.

Policy implications

More epidemiologic information is needed on the health status of residents of northern Wisconsin. To explain these high mortality rates, an area survey of health habits should be conducted. The health behaviors of most importance for such a survey are cigarette smoking (including passive smoke exposure),[4] alcohol use, exercise, and diet. Psychological factors, such as attitudes toward risk-taking, could differ in this area. It is possible that greater individualism and less personal responsibility for the health of self and others might lead to risky health behaviors.

Given the high death rate due to heart disease in this region of the state, it seems prudent to increase prevention and risk reduction efforts. Educational efforts are needed, and should include media, organizations, physicians offices, and schools. Governmental efforts may include increasing taxation on cigarettes (a "health tax"), taking effective action to limit smoking by children, and removing cigarette machines. Area-specific appeals (including the facts of the area death rates, and special emphasis on smoking) should be made. Some of these educational activities are now being done on a small scale by voluntary organizations but would have to be intensified to have a more appreciable effect.

Series coordinators
The Wisconsin Division of Health's Patrick Remington, MD, and Henry Anderson, MD, are coordinating this series for the *Wisconsin Medical Journal*. This series is intended to help inform physicians on public health policies and considerations. The public health column is not reviewed by the *WMJ* Editorial Board.

Acknowledgements

The author thanks Patrick Remington, MD, Ray Nasholt, PhD, Dennis Anderson, and Paula Lantz, PhD, for their helpful comments.

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2. Wisconsin Division of Health. Annual vital statistics reports.
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Heart disease deaths, 1969-1981, Wisconsin's Northwestern HSA.

Age group	Observed number of deaths	Expected number of deaths*	Difference (excess)
<35	44	29	15
35-54	316	275	41
55-64	988	789	199
65-74	2,287	1,969	319
75-84	2,636	2,430	206
85+	1,964	1,739	225
All ages	8,235	7,230	1,004

*Based on average state mortality rate, 1969-1981.

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Discovery at Prairie du Chien: the story of Dr William Beaumont

Before he was 19 years old, Alexis St Martin–a squat, brawny French-Canadian youth–was known at Fort Mackinac as a great eater and drinker, and a spinner of blasphemous tales.

In fact, St Martin's stories were so comical and entertaining he eventually told one that caused a colleague at the American Fur Company store to double over with laughter and drop his loaded shotgun; it fired point blank into St Martin, who fell, unconscious.

Within minutes William Beaumont, MD, the post doctor, was examining a great hole in St Martin's stomach. The 37-year-old physician solemnly pointed out that if the young man lived beyond 20 minutes, it would be a miracle. The year was 1822.

Much to Dr Beaumont's surprise, St Martin continued to live, battling pneumonia and infection. At the end of 4 weeks his digestive system was functioning smoothly. Eventually he expelled the shot, wadding, and pieces of cartilage. But no matter how hard the doctor tried, he could not get the hole in the stomach to close. A linen compress or bandage, therefore, was needed to keep food and drink from flowing out.

As the wound healed, a valvular formation appeared in the coats of the stomach. It adapted itself to the new orifice and consequently prevented the efflux of gastric contents when the stomach was full, yet it was easily depressed with the finger. Dr Beaumont devised a stomach plug and by Feb 1, 1823, he pronounced his patient in "perfect health," considering his circumstances. St Martin still could not walk as a result of his injury, however, and required significant care.

In April 1823, Dr Beaumont opened a letter from the Mackinac (pronounced Mak-eh-naw) County Charity Fund to discover that St Martin's medical expenses had depleted the funds. The message instructed the physician to release his patient so he could be returned via canoe to Quebec–2,000 miles away.

Dr Beaumont pleaded for more funding, but his requests were denied. To permit St Martin to embark on a 2,000-mile voyage in an open canoe meant certain death. To resolve this quandary, the young physician made a difficult choice. He brought the injured St Martin in his own home and continued to care for him on a bed set up in the family's living room. Dr Beaumont also took responsibility for the poor man's medical expenses at a time when the army physician's income was a mere $40 per month and two to four food rations per day.

All attempts to close the wound were unsuccessful, and finally St Martin forbid any more surgery toward that end. The complete recovery of St Martin, except for the fistula in his stomach, began to lead Dr Beaumont to consider the feasibility of conducting tests to learn what became of liquids and foods taken by mouth. Three years after the shooting, Dr Beaumont commenced his first actual experiments.

William Beaumont, MD

Through that hole in St Martin's stomach, Dr Beaumont made what is considered one of the major discoveries of medical science: He found out how man digests food. He did this by paying St Martin $160 a year to let him drop bits of food tied to surgical string into the youth's stomach. He then timed how long it took the pieces to be digested. He dropped everything from a thermometer to a dozen raw oysters and port wine into the hole.

The first of the 56 experiments conducted at Prairie du Chien were made to establish the normal temperature of the stomach. The physician learned that the temperature of air and moisture had

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Dr Beaumont attends to Alexis St Martin at Ft Crawford. Portrait courtesy of the Ft Crawford Medical Museum in Prairie du Chien.

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some effect on stomach temperature. He also found that digestion of food taken out of the stomach during digestion, then placed in a dish on a sand bath at the same temperature of the stomach, was digested nearly as quickly and completely as the food that remained in St Martin's stomach. He discovered that food placed in St Martin's stomach through the fistula was digested as well and as rapidly as food taken my mouth.

Dr Beaumont and St Martin had a tumultuous relationship that resulted in long periods of separation. At one point the doctor described St Martin in his journal as a "dirty, slovenly fellow, unreliable and given to drink." Yet for all their differences, the doctor was able to conduct more than 200 experiments on the Canadian.

Dr Beaumont's findings were revolutionary, revealing the physiology of the stomach and digestion. He accurately described the gastric juice itself, identifying it as a separate secretion from mucus. By sending samples of stomach juices to the East for analysis, he was able to confirm Proust's former observation that the fluid contained muriatic or hydrochloric acid. Dr Beaumont also discovered the presence of an all-important enzyme, later identified as pepsin.

The US Army physician established the influence of mental and emotional disturbances on the secretion of gastric juices. As the restless St Martin grew tired of the doctor's demanding and condescending nature, Dr Beaumont was also able to record significant data on the effects of anger on digestion.

Surprisingly, Dr Beaumont's isolation and lack of conveniences had much to do with the success of his experiments. He realized that he did not have quality research equipment and was not properly grounded in the scholarly background of the physiology of digestion. He was, therefore, determined to proceed carefully, to ignore hypothesis and theories as much as he could, and to put down only facts:

"I make no claim to originality in my opinions," he noted in his papers, later adding, "I consider myself but a humble inquirer after the truth–a simple experimenter."

Dr Beaumont's simple expression of faith in experimental methods has provided inspiration for many.

Born on a farm in Lebanon, Conn, in 1785, Dr Beaumont received a common school education. At age 21, he left home for Champlain, NY, near the Canadian border, where he would teach elementary school and read of medicine. Three years later, he became an apprentice in the office of Dr Benjamin Chandler in St Albans, Vt. There he did all sorts of duties, from sweeping the floor to assisting in surgical procedures.

In 1812, Dr Beaumont became a licensed practitioner through the Vermont Medical Society. But shortly thereafter, the War of 1812 broke out and he was commissioned as an army surgeon's mate. The carnage of the battlefield took an emotional toll on Dr Beaumont. At the end of hostilities, he resigned from the army, and took up private practice in Plattsburgh, NY.

But the frontier physician was not destined to be a civilian for long. He reentered the service in 1820 and was assigned to Fort Mackinac, Mich, as a post surgeon. There he married a young widow, Deborah Green Platt of Plattsburg.

With quill and ink in hand, Dr Beaumont set out in 1824 to record his unique experiments. He finished the piece and sent it off to Surgeon General Joseph Lovell for review. Lovell responded favorably and said he would send it in to the journal, *Medical Recorder,* for Dr Beaumont. The journal published the article early in 1825, but someone at the printing end mistakenly credited to General Lovell. The mistake was duly noted in a later edition.

Encouraged by reaction to the article, Dr Beaumont began to wonder if the isolation and lack of available equipment in Prairie du Chien would hamper his scientific progress. He put in for a transfer to an eastern post and by June 1825 he was working at the Fort Niagara (NY) hospital. Deborah and the children moved in with her parents in Plattsburgh until arrangements could be made for family housing at the fort.

Dr Beaumont kept St Martin with him at the fort, and the experiments continued. But this new-found proximity to Canada was more than the beleaguered St Martin could stand; and so, some time in August the "man with the lid on his stomach" simply disappeared. About the same time, a directive came from the War Department granting Dr Beaumont a 2-month furlough to make up for a lack of vacation. Dr Beaumont hunted for St Martin throughout his leave, but could discover no clue as to his patient's whereabouts. Dejected, he returned to the fort and the task of writing up his most recent research.

Not long after, Dr Beaumont was ordered to pack all medical supplies under his charge and accompany the troops to a fort at Green Bay. Deborah stayed behind with the children at Plattsburgh and was a faithful correspondent. But one of her letters brought tragic news for Dr Beaumont: his infant son William had died. As soon as the funeral was over, his wife and small daughter joined Dr Beaumont in Green Bay.

By 1828, the family was back in Prairie du Chien and well established; a daughter was added to the ranks. Then the news came in 1829: St Martin had been located. The St Martins (by this time Alexis had a wife and two children) were transported 2,000 miles to the Beaumonts.

Dr Beaumont's experiments in Prairie du Chien were conducted in the old log Fort Crawford. While at Prairie du Chien, Dr Beaumont received permission in 1831 from his friend and superior, Surgeon General Lovell, to take St Martin to visit some well-known European physiologic chemists. Conflict between the American Indians and the US government erupted shortly before he was scheduled to depart, and the trip was cancelled.

Dr Beaumont served in the Black Hawk War of 1832 and was present at its concluding battle at Bad Axe on Aug 2. While at the fort during the 1830s, he made several observations on intermittent fever or malaria. The Wisconsin physician described the malady clearly, although he did not pinpoint the role mosquitoes play in carrying the disease.

The physician left Prairie du Chien on Aug 23, 1832, in charge of the wounded prisoners of the Black Hawk War. He took St Martin with him, planning to take advantage of the furlough granted so that he could demonstrate the truth of his experiments to the great Swedish chemist, Berzelious. But the trip never transpired. The government would grant him only 6 months leave, barely enough time to travel back and forth, and certainly not enough time for thorough study. Dr Beaumont opted to continue his work in the East, but never dreamed he was leaving Prairie du Chien behind for good. All his plans were for his return to the new hospital at the fort where he hoped to complete his experiments on human digestion. St Martin was contented among the French-Indians of the village so akin to his own people in Canada.

When the furlough was over, however, Dr Beaumont's request to be sent back to Prairie du Chien–or even Green Bay–was ignored. The army ordered him to St Louis.

St Martin returned to Canada with Dr Beaumont's approval. He and his wife expanded their family to 17 children, but only five lived to adulthood. St Martin died in his 80s, living more than 60 years with the unique fistula in his stomach. St Martin's body was buried by the family 8

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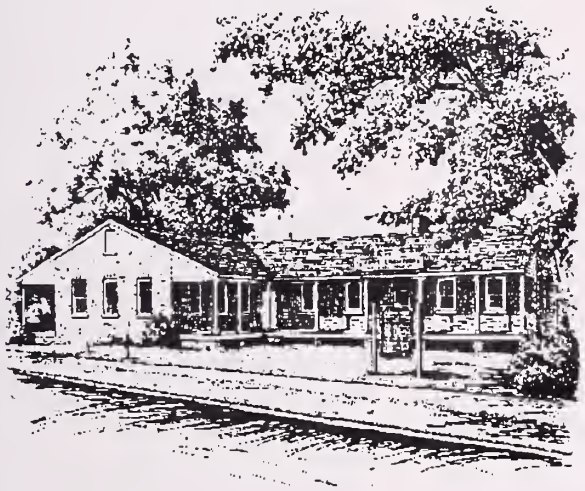

This reconstructed military hospital at Fort Crawford is a national historic landmark set in the Mississippi River Valley.

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feet deep in an unmarked grave to protect it from the overly curious.

Dr Beaumont resigned his military duties in 1839 and established a private practice in St Louis. In 1840, he was offered a chair of surgery at the first medical college established west of the Mississippi. He was also elected president of the St Louis Medical Society.

As the years past, Dr Beaumont lived a busy and challenging life. On a cold evening in March 1853, while coming home from a house call, he slipped on some icy, stone steps and struck his head. Dazed by the hard fall, he wandered until a friend recognized him and took him home. Although a physician declared that the injury was not serious, Dr Beaumont predicted that his injury would end in paralysis or death. He continued to work, and with the help of his son, put all his affairs in order. Then without warning, infection and fever struck. Death came quickly on April 25, 1853.

Set near the junction of the Mississippi and Wisconsin rivers, the area now known as Prairie du Chien has known myriad historic figures, from Marquette and Joliet to Red Bird and Black Hawk. But not one of members of that long list did more for mankind than Dr Beaumont, whose unique experience and careful work constituted "the greatest contribution ever made to the knowledge of gastric digestion."

Some of the historical data found on Dr Beaumont was obtained from a WMJ article by Edward P. Alexander of the State Historical Society and from the archives of the SMS. LeeAnn Kahlor complied much of the research for this article.

A glimpse into our past

Richard D. Sautter, MD, *medical editor*

25 years ago

The rising costs of health care. A study by the federal government found medical costs rising "faster than other prices." One factor cited as a cause was the demand for health care was out-pacing the supply. During the period of study (1950-1965), the population grew by 28% and the per capita disposable income grew by 34%. Rising hospital costs were also cited, with the tightening labor market, increased demand and inefficiency as the underlying causes.

One proposed solution to the physician shortage was creation of the "short-term" doctor who trained for 5 years instead of 9. The chair of the University of Wisconsin Department of Medicine advocated this idea and said the "short-term" doctor would be used primarily for routine care, such as immunizations and prenatal care. The SMS president thought it possible and prudent to "develop physician assistants as the `Felschar' system of Russia." These he described as "well trained social workers."

A sign of the times. Walter J. Tardy, of Madison, was the first black physician to receive a doctor of medicine degree from the University of Wisconsin. He graduated June 5, 1967. Dr Tardy now resides in Dallas.

50 years ago

The end, and the beginning, of an era. Charles H. Crownhart was selected as the new SMS secretary. He succeeded his brother, J. George Crownhart, who became the first full-time SMS secretary in 1923 and remained in that position until his death in 1941. Charles Crownhart served as SMS secretary until his retirement in 1970.

A tale of inflation. An oak examining table, used "but in good condition," was advertised for sale in the *WMJ*: the asking price was $8. An x-ray machine sold for $280, installed.

Some problems have history. A scientific presentation at the annual meeting discussed the uses and abuses of barbiturates, noting that the number of "suicides by barbiturates have been increasing over the years, but many states have now restricted the sale of the drug to prescriptions by physicians."

Not a bad idea. As a part of its public education efforts, the SMS published an 8-page booklet of paraphrased nursery rhymes with health messages. *Mother Goose Health Rhymes* was distributed at county fairs throughout the state. (If anyone has a copy, I'd like to see it.)

75 years ago

The perspective of time. The divorce rate reported for in Wisconsin was 0.84 per 1,000 population (1925), which prompted the state Board of Health to publicly declare: "Divorce is an evil at the root of our social structure and is a result of the era of moral wane which our country has undergone since the World War. Some people attempt to assign the increase of divorce to the enfranchisement of women, for women are realizing their rights and independence and are refusing to submit to their husbands as their lords and masters." (Male chauvenist pigs have been with us for a long time.) The divorce rate for Wisconsin is now 3.6 per 1,000 (1989).

Good work if you can get it. A combined medical practice and drug store were offered for sale through the *WMJ*. As an enticement to buy, the ad promised:

"Purchaser will have money coming in first day, and can clean up $5,000 a year."

Some problems have too much history. Dr Gerald K. Wooll addressed the Janesville Lions Club on the subject of drug abuse. He urged parents to train their children to "beware of strangers who offer anything to taste" and told the club that "legislation should be promoted to curb the curse drugs (were) leaving everywhere." Heroin was the drug of special concern. (Things don't change as much as they stay the same.)

100 years ago

Surgical advice offered: A dirty hand cannot do antiseptic surgery.... Be methodical.... Instruments should be selected for their simplicity of construction.... Two assistants are ample.... No talking, especially story telling and laughing, is to be tolerated.

Suicide for the SMS? The question of whether the annual meeting should attach a banquet to its reading of scientific papers was robustly debated. One physician insisted that such a banquet would "be suicidal to this Society," because he thought it would cause fewer physicians to join and many to quit (himself included).

"Did you ever reflect that you do not represent one eighth of the physicians of this state?" he asked. "And still you propose to start out in this Society and make it a club, where you can gormandize ... put on paraphernalia, march, make a splendid display in the street and gather your orators.... I believe the proposition, if adopted, will create prejudice against this Society." (Boy, was he wrong!)[15pt4]

SMS Board of Directors adopts new guidelines on HIV-infected health care workers

At its December 18 meeting in Madison, the SMS Board of Directors adopted, as SMS policy, a new set of guidelines for HIV-infected health care workers. The guidelines were created by the SMS Task Force on AIDS, chaired by SMS President Cyril M. "Kim" Hetsko, MD. The full text of the guidelines follows.

The overall common goal of health care professionals is to serve and protect their patients.

The only significant modes of transmission of HIV are exchange of blood or body fluids, most commonly through injection drug use or sexual contact, and vertical transmission from mother to child. Recent and ongoing analysis indicates that the risk of transmission from an HIV-infected health care worker to a patient is highly unlikely, and an extremely rare possibility.[1,2] The potential transmission of HIV infection in the health care setting is best prevented by the use of universal precautions and proper barrier techniques.

The SMS recognizes that there has been considerable media and political attention given over the past year to the public concerns about health care workers infected with HIV. The intensity of this attention is inappropriate in light of the minimal risk to patients, and the degree of public concern is unsupported by scientific evidence.

Congress passed legislation in October 1991, calling for state public health officials to implement guidelines to prevent HIV transmission from health care workers to patients. While the scientific data does not support significantly restricting the practices of health care workers with HIV, the strength of the public's desire to restrict the activities of HIV-positive health care workers and the depth of the medical profession's need to maintain the public's trust cannot be ignored.

Therefore, we conclude:

a. The potential transmission of HIV infection in the health care setting from patient to health care worker as well as vice versa, is best prevented by the use of universal precautions and proper barrier techniques. Therefore, we recommend that all physicians and other health care workers must follow universal precautions.
b. The confidentiality and the civil rights of health care workers, as well as patients, must be protected.
c. Routine or mandatory HIV testing of health care workers, or even specific categories of health care workers , is not recommended, nor should it be a requirement for employment, credentialing, licensure, or professional liability insurance.

   Routine or mandatory testing would involve substantial costs with minimal benefits. Further, such a testing policy would raise substantial civil rights concerns, especially in light of existing state laws prohibiting involuntary testing and prohibiting discrimination on the basis of HIV status.
d. All health care workers are encouraged personally to assess their own need for HIV testing. Testing must be on a voluntary basis. These assessments should include known high-risk behaviors, as well as risks associated with health care-related occupational exposure. If health care workers are at risk, they should learn their HIV status to protect and improve their health and to receive appropriate medical and occupational counseling.
e. HIV-positive status by itself should not

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not be the basis for any restriction of the practice of medicine or surgery.

While HIV infection, per se, does not impair a health care worker's ability to perform his or her duties, complications or disease sequelae may. Infected health care workers should seek appropriate medical care and periodic evaluation of health status, and counseling on the advisability of continuing to work in health care or continuing particular activities. Monitoring by the health care worker's personal physician should be sufficient to determine whether such impairments in the health care worker exist.

When the health care worker's personal physician determines that such impairments may exist, it is advised that the infected health care worker, with the advice of his or her physician, request that an ad hoc committee be constituted to consider any suspected or documented impairments. This committee should evaluate the health care worker's compliance with infection control protocols and mental and physical competence to continue to practice. Membership of the committee may be composed of, but not necessarily limited to, an infectious disease specialist familiar with HIV disease, a person of the same professional specialty as the infected health care worker, the infected health care worker's personal physician, a person with expertise in infection control, and the infected health care worker.

If the health care worker is practicing in an institution, then such a committee may be created within that institution. Other options include a local, regional, or professional society advisory committee. Absolute confidentiality must be maintained by any such advisory committee. The committee and the HIV-infected health care worker should be protected with indemnification against liability for actions as a result of this committee's deliberations.

f. Support must be provided for the HIV-infected health care worker with regard to employment continuation, disability coverage, and long-term health insurance availability.

The Task Force on AIDS will continue to study the issue of health care worker-to-patient transmission of HIV. If appropriate, these conclusions and recommendations will be modified, as new and definitive evidence becomes available. We encourage further national and state studies into this issue.

1. Lowenfels AB, Wormser GP. Risk of transmission of HIV from surgeon to patient. *N Engl J Med.* 1991;325(12):888-889.
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Physician briefs

J. Frank Wilson, MD,* professor and chair of radiation oncology at the Medical College of Wisconsin and an internationally known researcher in radiation therapy for cancer, has been installed as president elect of the American Society of Therapeutic Radiology and Oncology. Dr Wilson, a fellow of the American College of Radiology, was named department chair in 1985. He has presented several national and international lectures on radiation therapy as an alternative to mastectomy for breast cancer.

Daniel G. Koster, MD,* a family physician, has joined the Mount Horeb office of Physicians Plus Medical Group.

David K. Falk, MD,* of Madison, has been elected president of the 110-member Wisconsin Dermatological Society. Dr Falk is a dermatologist with Dean Medical Center.

Timothy W. Harnstad, MD, of West Allis, was recently appointed assistant professor of obstetrics and gynecology at the Medical College of Wisconsin. Prior to joining MCW, Dr Harnstad was associate director of maternal-fetal medicine at the Maine Medical Center in Portland, and was assistant professor of obstetrics and gynecology at the University of Vermont College of Medicine. A native of Wisconsin, he earned his medical degree from the University of Wisconsin-Madison in 1979.

Sridhar V. Vasudevan, MD,* of Milwaukee, was recently elected president of the newly formed American College of Pain Medicine (ACPM). Dr Vasudevan is the chair of the Department of Physical Medicine and Rehabilitation at St Joseph's Hospital in Milwaukee.

Dale A. Gerdes, MD, has been appointed assistant professor of internal medicine and physician in the section of emergency medicine at University of Wisconsin Hospital and Clinics in Madison. Dr Gerdes received his medical degree from the University of Nebraska-Omaha, and served a residency at Hennepin County Medical Center in Minneapolis.

Nizar N. Jarjour, MD, was recently appointed assistant professor of internal medicine and attending physician in the department of medicine at University of Wisconsin Hospital and Clinics. He received his medical degree from Damascus University School of Medicine in Syria

and served a residency at Cook County Hospital in Chicago and a pulmonary critical care fellowship at University of Wisconsin Hospital and Clinics.

Athena Daniolos, MD, has been named assistant professor of internal medicine and will practice dermatology at the University of Wisconsin Student Health Service. She received her medical degree from the University of Texas Southwestern Medical School in Dallas and served a residency in internal medicine at the University of Connecticut Health Center and a dermatology fellowship at Yale University.

Pamela O. Black, MD, was named a fellow of rehabilitation medicine at the University of Wisconsin Medial School and at UW Hospital and Clinics. She received her medical degree from UW Medical School and served a residency in rehabilitation medicine at UW Hospital and Clinics.

Deborah L.P. McLeish, MD, was recently appointed assistant professor of rehabilitation medicine and director of pediatric rehabilitation at University of Wisconsin Children's Hospital. She received her medical degree from the University of Wisconsin Medical School and served a pediatrics residency and physical medicine and rehabilitation medicine residency at University of Wisconsin Hospital and Clinics, was a pediatrician at Jackson Clinic Urgent Care Center in Madison and nutrition coordinator for the Wisconsin Women, Infants and Children program.

Charles L. Woodhouse, MD,* of Eau Claire, has received a 3-year appointment as Cancer Liaison Program for the Cancer Program at Luther Hospital in Chicago.

Ronald Martins, MD,* of Elm Grove, was recently elected area medical director of the American Cancer Society Wisconsin Division board of directors. Martins will assist in determining policies and programs for all areas of the American Cancer Society Wisconsin Division.

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Continued from preceding page
Beatriz Somoza, MD,* a family physician, has joined the Crossroads Family Care Center in Oxford and the staff of Divine Savior Hospital in Portage. Dr Somoza earned her medical degree at University CETEC in Santo Domingo, Dominican Republic, and recently completed her family practice residency in Omaha, Neb.

Milton R. McMillen, MD,* an emergency physician at St Francis Medical Center, received the Professional Practice Award from the American Heart Association in recognition of his 10 years of leadership in providing emergency cardiac care instruction for health professionals.

Rocky Lipsman, MD, a specialist in otolaryngology, has joined the medical staff of the Wausau Hospital Center.

Thomas C. Gabert, MD,* is the newest addition to the Marshfield Clinic-Lakeland Center staff. An internist, Gabert joined the Lakeland Center from Wausau Medical Center, where he was a medical staff member since 1988. Dr Gabert earned his medical degree at the University of Wisconsin Medical School and served a residency in general internal medicine at Marshfield Clinic-St Joseph's Hospital.

Michael S. Wolkomir, MD, was recently appointed assistant professor of family medicine at the Medical College of Wisconsin. He is also assistant director of the MCW family practice residency program at St Michael's Hospital in Milwaukee. After receiving his medical degree in 1974 from McMaster University in Ontario, Canada, Dr Wolkomir served a mixed internship in internal medicine, surgery, obstetrics and psychiatry at McMaster University Hospitals. He served a residency in OB/GYN at St Joseph's Hospital and in family practice at St Mary's Hospital in Milwaukee.

Thomas J. Gvora, MD, has been named an assistant professor of medicine at the Medical College of Wisconsin. Dr Gvora will spend the majority of his time working with residents and students in an outpatient setting. Dr Gvora is a graduate of the University of Wisconsin Medical School. He completed a residency in internal medicine at St Elizabeth's Hospital in Boston, an affiliate of Tufts University Medical School, and served as chief medical resident at St Elizabeth's after completing his residency.

Rick D. Gillis, MD,* was recently appointed assistant professor of medicine at the Medical College of Wisconsin. He practices general internal medicine at the Milwaukee County Medical Complex and Froedtert Memorial Lutheran Hospital. Dr Gillis completed in residency in internal medicine at MCW in 1990. He received his medical degree from MCW in 1988.

Tom Sullivan, MD,* has joined the staff at Belleville Family Medicine Clinic. A graduate of the Northwestern Medical School in Chicago, Dr Sullivan did an internship and residency at St Mary's Hospital in Madison. He was a partner in the Prairie Clinic in Prairie du Sac for 10 years.

James Weber, MD, a senior research scientist at the Marshfield Medical Research Foundation, has been named the recipient of Gwen D. Sebold Research Fellowship. Dr Weber was nominated by his colleagues for his world class research in human genetics. His current projects include analysis of an abundant class of human DNA polymorphisms; linkage mapping of Tourette Syndrome genes; and an epilepsy program project. Past recipients of the research award include **Richard Sautter, MD,* Dean Emanuel, MD,* and Duane Tewksbury, MD.**

William G. Anderson, MD,* has been appointed medical director for the Village Center at Milwaukee Psychiatric Hospital, Wauwatosa. He succeeds **Sheila Sorkin, MD,** who has been named the medical director of the alcohol and drug treatment program at Sheboygan Memorial Hospital.

Donald P. Hay, MD,* chief of the geriatric psychiatry program at St Mary's Hill Hospital, Milwaukee, and director of the division of geriatric psychiatry at the Medical College of Wisconsin, has been named to participate in the planning of a mental health agenda for the 1993 White House Conference on Aging.

John W. Beasley, MD,* of Madison, has been appointed chair of the American Academy of Family Physicians Committee on Research. Dr Beasley, a family physician, is also president of the Wisconsin Academy of Family Physicians, director of the Wisconsin Research Network and an associate professor at the University of Wisconsin.

Richard J. Rodarte, MD, is the new medical director of the Center for Occupational Health at Memorial Hospital of Burlington. A family physician, Dr Rodarte recently completed a term as president of the medical staff of Memorial Hospital and is vice president of Burlington Clinic. He teaches at St Luke's Family Practice Center in Milwaukee.

Susan Carson, MD,* Megan Landauer, MD, and **James Nettum, MD,*** have joined Physicians Plus Medical Group. Dr Carson is a family physician in Waunakee; Dr Landauer is an OB/GYN at the East Towne clinic in Madison; and Dr Nettum is a family physician at Quisling Clinic in downtown Madison.

David J. Kuester, MD,* has joined the Orthopaedic Associates of Manitowoc. A native of Racine, Dr Kuester obtained a medical degree at Columbia University, College of Physicians and Surgeons, New York, NY. He interned at Beth Israel Hospital, New York, and received completed a residency in Memphis, Tenn.

Jeff Squires, MD, is the newest addition to the staff of the River Valley Medical Clinic in Frederic. Dr Squires, a dermatologist, earned his medical degree at the University of Minnesota before going on to complete an internship at La Crosse Lutheran Hospital and a 3-year residency at the University of Minnesota.

Glenn Smiley, MD,* of Delavan, was recently elected an honorary life member

of the American Cancer Society Wisconsin Division board of directors. Dr Smiley has been a volunteer with the American Cancer Society since 1959 and is a former board president.

Elliott Goulden, MD, Berlin, was recently elected area medical director of the American Cancer Society Wisconsin Division board of directors. In this capacity, Goulden will assist in determining policies and programs for all areas of the cancer society, including public education, service and rehabilitation, finance, field services and public issues.

John D. Van Liere, MD,* of Burlington, recently was awarded a citation by acting air surgeon Dr Jon Jordon of the Federal Aviation Administration in Washington, DC, in recognition of his interest in aviation safety as an aviation medical examiner from 1949 through 1991.

Thomas Ho, MD,* has been appointed to the professional advisory board of Midstate Epilepsy Association. Dr Ho is an internist with Doctor's Clinic in Wisconsin Rapids and a graduate of Minnesota-Minneapolis Medical School.

Brad A. Baldwin, MD has been invited to be a board examiner for the National Surgical Certifying Board. Dr Baldwin is affiliated with Doctors Park in Platteville.

Tom Kowalski, MD is the new medical advisor for the Cudahy Health Department. Kowalski will serve a 2-year term, replacing Dr Carl J. Chelius, who retired from the office this year after serving 31 years.

Thomas I. Gibbon, DO, a general practice physician, has joined the medical staff of Elroy-Gundersen Clinic. A native of Kellogg, Idaho, Dr Gibbon received his DO degree at the University of Health Sciences, Kansas City, Mo, in 1987. He completed his internship at the Oklahoma Hospital, Tulsa, in 1988.

Paul R. Bolich, MD,* a radiologist, has been elected president of the Wisconsin Radiological Society. Dr Bolich is a 1970 graduate of the University of Michigan Medical School. He served his internship and residency at University of Wisconsin Hospital in Madison.

SMS representatives to the recent AMA interim meeting: (l to r) John Mullooly, MD, of Milwaukee; SMS Deputy Secretary James Paxton, of Madison; Timothy Flaherty, MD, of Neenah; Kenneth Viste, Jr., MD, of Oshkosh; Susan Turney, MD, of Marshfield; and Patricia Stuff, MD, of Shawano. Photo courtesy of Mark Vukelich, director of communications for the Minnesota Medical Association.

Ken Gold, MD, an internist affiliated with the Beloit Clinic, was a delegate to the 35th annual meeting of the American Society of Internal Medicine, held in Washington, D.C.

Jack Geist, MD,* has been named the first Geriatric Psychiatry Fellow by the Medical College of Wisconsin, Wauwatosa, and St Mary's Hill Hospital, Milwaukee. The program incorporates clinical and educational activities at the two institutions.

Jan Van Schaik, MD, is the new medical director of the Wells Program of Milwaukee Psychiatric Hospital, replacing Erol Gray, MD, who moved to California. Dr Van Schaik has been a member of the hospital's medical staff for 8 years, specializing in the treatment of mood disorders. He is also an assistant clinical professor of psychiatry at the Medical College of Wisconsin.

Kenneth Mitchell, MD, Arthur Norris, MD,* John Pankiewicz, MD,* and Yvonne Reid, MD, have recently joined the staff of the Milwaukee County Mental Health Complex. Dr Mitchell, a graduate of the Harvard University Medical School and recent chief of service at a psychiatric center, will work on acute adult inpatient service. Dr Norris earned his medical degree from the Medical College of Wisconsin and most recently, has served as medical director of Mendota Mental Health Center. Dr Norris will concentrate on geropsychiatry. Pankiewicz, a graduate of the University of Illinois College of Medicine, recently completed a psychiatric residency at the Medical College of Wisconsin. He will work with the court program. Dr Reid, a resident at the University of Wisconsin-Milwaukee Psychiatry Program, will work in the outpatient program at the south side and Cudahy clinics.

William Olson, MD, of Greenwood, was the honored guest at a recent town football game, where high school students rededicated the football field in his name. Dr Olson was a member of the school board when the football program was just beginning. He bought the land for the football field and had it developed before donating it to the school. Dr Olson has also served as team doctor over the years.

Ann Marie Gierl, DO,* of Appleton, has joined the staff of La Salle Clinic as a rheumatogist. Dr Gierl earned her degree from the College of Osteopathic Medicine and Surgery in Des Moines, Iowa, before serving her residency in internal medicine at NorthWestern University's Evan-

Continued on next page

Kermit Newcomer, MD, (l) of La Crosse, and Robert Purtell, MD, (r) of Milwaukee, at the recent AMA interim meeting. Dr Newcomer serves on the AMA Council on Medical Services, and Dr Purtell is an alternate delegate. Photo courtesy of Mark Vukelich, director of communications for the Minnesota Medical Association.

Continued from preceding page
ston (Ill) Hospital. She completed a 2-year fellowship training program in rheumatology at Cleveland Clinic Foundation.

Pamela V. Lois, MD,* of Sheboygan, is the new area medical director of the American Cancer Society-Wisconsin Division board of directors. Her nomination was confirmed at the Wisconsin Division Annual Meeting by 250 volunteers from throughout the state.

Brenda J. Dierschke, MD, Karl R. Noll, MD,* and Marlene J. Schmidt, MD, recently joined the staff at Gundersen Clinic in La Crosse. Dr Dierschke is a physiatrist. Dr Noll is a dermatologist. Dr Schmidt is a child and adolescent psychiatrist.

Robert M. Gullberg, MD,* of Racine, has been accepted into the Fellowship of the American College of Physicians. Acceptance is based on aptitude, scholarship and teaching. Gullberg, who practices general internal medicine at Racine Medical Clinic, is an infectious disease specialist for Racine County.

Gwen A. Johnson, MD,* of West Bend, has been named a diplomat of the American Board of Family Practice (ABFP) after passing a certification examination. Dr Johnson is now certified in the specialty of family practice.

Richard A. Brandner, MD,* has joined the staff at the Rhinelander Medical Center, SC, Eagle River office. Dr Brandner earned his medical degree at the Medical College of Wisconsin in 1975. He completed his residency in 1978 at St Mary's Hospital in Milwaukee. He is also a registered pharmacist in Wisconsin.

Kenneth Gold, MD,* will take on the duties of vice president of medical affairs at Beloit Memorial Hospital beginning March 1. Dr Gold is in practice at the Beloit Clinic. He earned his medical degree from the State University of New York Health Science Center in Brooklyn and served his residency in internal medicine at University Hospital in Columbus, Ohio and a fellowship in psychiatry and medicine at the University of Rochester Strong Memorial Hospital.

Robert Montgomery, MD, has been named the recipient of the Dr Murray Thelin Award by the National Hemophilia Foundation. Dr Montgomery is the vice president and director of research for the Blood Center of Southeastern Wisconsin, Milwaukee, and is the scientific director of the Great Lakes Hemophilia Foundation. The award honors him for his contributions to scientific research in hemophilia and related blood clotting disorders.

Mary Jo Neustifter, DO,* Shatwant Dhillon, MD,* Ronald E. Beresky, MD, and Beth Ellen Hothan, MD, have expanded their practices to serve Edgerton area residents. Dr Neustifter earned her medical degree from the Chicago Osteopathic College and completed her residency at Cook County Hospital in Chicago. Dr Dhillon graduated from the Wayne State School of Medicine and completed his residency at the University of Wisconsin hospitals and clinics. Dr Beresky, a member of the Dean Clinic, has practiced surgery in Stoughton since 1989. Prior to coming to Wisconsin, he was chief of general surgery at Winn Army Community Hospital in Fort Stewart. Dr Hothan has been affiliated with the Surgical Center of Fort Atkinson since 1986. She graduated from the University of Illinois in 1981 and completed her residency at St Francis Medical Center in Peoria, Ill.

Mark A. Huftel, MD,* recently joined the Wausau Medical Clinic as a specialist in the diagnosis and treatment of allergies. Dr Huftel earned his medical degree from University of Wisconsin-Madison, served his residency in Milwaukee and completed a 2-year fellowship in allergy and immunology at University of Wisconsin-Madison.

Kenneth M. Viste, Jr., MD,* of Oshkosh, medical director of the St Agnes Hospital

Center for Physical Rehabilitation, has been awarded the Wisconsin Rehabilitation Association Individual of the Year Award. Dr Viste has been a member of the St. Agnes Hospital medical staff for almost 20 years.

Kimball S. Fuiks, MD, a neurosurgeon, has joined the staff at Mercy Hospital in Janesville. Dr Fuiks received his medical degree from the University of Connecticut School of Medicine, has been practicing in Philadelphia. Dr Fuiks was also an instructor at the University of Tennessee College of Medicine.

Susan L. Turney, MD,*, of Marshfield, is the 1991 recipient of the Wisconsin Society of Internal Medicine's Addis Costello Internist of the Year Award. Dr Turney serves on the Advisory Committee on Medicare-Physician Relationship of the Health Care Financing Administration (HCFA) and has served on various SMS committees. Dr Turney is chair of the Department of General Internal Medicine at the Marshfield Clinic; a clinical assistant professor of medicine at the University of Wisconsin Medical School and program director for the Transitional Residency at the Marshfield Clinic-St Joseph's Hospital.

Lawrence S. Larson, MD,* of Milwaukee, has been appointed chief of staff at St Michael's Hospital in Milwaukee.

Thomas F. Nikolai, MD,* of Marshfield, is a recipient of the Max Fox Preceptorship Award for 1991. Dr. Nikolai is an endocrinologist for the Marshfield Clinic and has served as clinical associate professor of medicine and a clinic professor of medicine at the University of Wisconsin.

Daniel L. Dale, MD and Richard R. Heckert, MD, have joined the staff of the Green Bay Eye Clinic. Dr Heckert earned his medical degree from Jefferson Medical College in Philadelphia, and completed his residency at George Washington University in Washington, DC Both physicians are certified by the American Board of Ophthalmology.

County society news

Green. At the December meeting of the Green County Medical Society the following physicians were accepted to membership: An-Yu Chen, MD; Charles W. Karpen, MD; Daniel Le, MD; Angela C. Miller, MD; and Tamara A. Scerpella, MD.

Marathon. George R. Edmonson, MD; Andrew Drewry, MD; Debra K. Markwardt, MD; Gabriel C. Ticho, MD; and Ralph H. Robertson, MD, were accepted to membership of the Marathon County Medical Society at the December meeting.

Outagamie. At the December meeting of the Outagamie County Medical Society, Diane E. Ahlman, MD; Stephen J. Heaney, MD; and Larry C. Livengood, MD, were accepted to membership.

Winnebago. Twenty-two members were present at the January meeting of the Winnebago County Medical Society to hear guest speaker, Mohan Peter, MD, of Oshkosh, speak on cardiac surgery. Veronic Solis-Rohr, MD, was accepted to membership in the society.[150th]

Elizabeth J. Zietlow, MD,* has joined Dr John P. Modrzynski in his Brookfield-area practice. A family physician, Dr Zietlow earned her medical degree from the Medical College of Wisconsin. She is a member of the American Academy of Family Physicians.

Michael R. Lunde, MD, of Waukesha, has been named a Fellow of the American Academy of Family Physicians.

Steven W. Ortell, MD,* of Shorewood, has been appointed chief staff psychiatrist at St Mary's Hill Hospital. Dr Ortell completed his medical education at the Medical College of Wisconsin and his internship with the Evanston (Ill) Hospital. His residency was completed at the Medical College of Wisconsin Department of Psychiatry.

Rudolfo Lastrilla, MD,* of Menomonee Falls, received a 1991 Award of Distinction from the American Heart Association of Wisconsin at its annual volunteer awards reception. An anesthesiologist, Dr Lastrilla received the AHA's Emergency Cardia Care Extended Service Award in recognition of his years of service as a CPR instructor.

John F. Kuglitsch, MD,* of New Berlin, recently joined the medical staff of Family Health Plan Cooperative and will be practicing at the Edgerton Health Center. Dr Kuglitsch, a board-certified internist, attained his medical degree from Marquette School of Medicine. His internship was completed at St Joseph's Hospital in Milwaukee. Dr Kuglitsch completed his fellowship in internal medicine at the Mayo Clinic, Mayo Graduate School of Medicine. Prior to joining Family Health Plan, Dr Kuglitsch practiced internal medicine at the Fond du Lac Clinic, SC, for more than 18 years.

Ian Gilson, MD,* is the recipient of the Milwaukee Academy of Medicine's Humanitarian Award given annually to an individual or group who has significantly improved the welfare of the community by virtue of courage, tirelessness, compassion and vision. Dr Gilson was chosen to receive this award for his work on behalf of persons with AIDS.

David LaFond, MD, has earned the Milwaukee Academy of Medicine's President's Award. Dr LaFond was chosen for this annual award because he has "immeasurably enriched the Academy by his presence, work and personification of our motto-non nobis nascimu-we are not born unto ourselves."[150th]

SMS secretary-general manager travels to the shores of Lake Michigan

Thomas L. Adams, CAE, secretary-general manager of the SMS, traveled twice to the greater Milwaukee area to visit with physicians, hospital staff and medical college faculty during November. The visits were part of Adams' ongoing outreach efforts that have taken him from Milwaukee to Superior in recent months.

Adams met with area physicians and discussed a number of state and federal issues, including AB655, which would provide a basic benefit pan to small employers; SMS efforts to increase reimbursement for physician services to Medical Assistance patients; and the SMS-supported 12-point plan for health care reform. Adams also reviewed physician efforts to improve implementation of the RBRVS.

The visits to the Milwaukee area included discussions with physicians at the Milwaukee County Medical Complex, St Francis Hospital, the Milwaukee Medical Clinic, and the Veterans Affairs Medical Center. Adams was assisted by SMS Field Representative Steve Whittow.

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

November 1991

*Brasington, Richard D., Marshfield
*Brister, G.H., Wausau
Dhamee, Mohammed Saeed, Milwaukee
*Foltz, Richard N., Wausau
*Geller, Kenneth A., Neenah
*Goldman, Ian L., Marshfield
*Goldstein, Paul H., Milwaukee
*Guevara, Esteban, Sheboygan
*Hardacre, Jerry M., Racine
*Hattenhauer, John M., Wausau
Hoffman, William K., Milwukee
*Immerman, Steven C., Eau Claire
*Jennings, Richard P., Beaver Dam
*Karen, Robert, Milwaukee
*Lee, Peter U, Beloit
Maski, Ravikant, Platteville
*Medich, Michael G., Green Bay
*Miller, Thomas O., Wausau
*Mockert, Thomas, Sheboygan
*Morrow, Kenneth A., Ashland
*Nandyal, Rajagopal R., Racine
*O'Connor, Thomas A., Milwaukee
O'Loughlin, Peter D., Necedah
Pearlman, Mary, Madison
*Pohl, Alan L., Milwaukee
*Saggio, Carl J., Fond du Lac
*Smith, Richard A., Elm Grove
*Wallace, James J., Oconto
*Zimmers, Herbert J., Milwaukee

December 1991

*Dicus, William T., Milwaukee
Engber, William D., Madison
*Finkel, Michael F., Eau Claire
Gillis, Beth L., Tigerton
*Gohdes, Paul N., Neenah
*Holmgren, Jeffrey P., Washburn
*Kuchipudi, Sarat B., Monroe
Mc Kinnon, William G., Chippewa Falls
Meany, Thomas B., Madison
*Meress, Steven G., Eldorado
Mieler, William F., Waukesha
*Miller, Charles H., La Crosse
*Minikel, Jeffrey L., Milwaukee
*Park, James V., Verona
*Paulsen, Frederic L., Marshfield
Polacek, Michael, Wauwatosa
*Rath, Edward K., New Berlin
*Rietbrock, Michael J., Oconomowoc
*Sack, Joseph G., Wausau
*Semler, William L., Milwaukee
*Simske, Clifford J., Stevens Point
Stewart, Richard D., Racine
*Sudbury, Russell S., Menomonie
*Westman, Jack C., Madison
*Wiedmeyer, Debra A., Brookfield

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The persons and organizations named below made contributions to the Charitable, Educational and Scientific Foundation from September through December 1991.

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In recognition of those individuals, county medical societies, and auxiliaries who contribute their support to the Fort Crawford Medical Museum.

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Jefferson County Medical Society Auxiliary
Dr and Mrs J D Kabler
State Medical Society of Wisconsin Auxiliary
Waupaca County Medical Society
Winnebago County Medical Society

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Contributions
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Gifts made from September through December 1991.

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Fond du Lac County Medical Society
Dr and Mrs Gerald Kempthorne
Mary Mokrohisky
Dr and Mrs E. J. Nordby
State Medical Society of Wisconsin

In Memoriam

In loving memory of those individuals who will grace our paths forever.

Kenneth L. Bauman, MD
Nelson A. Bonner, MD
Arnold A. Cook, MD
Gabriel P. Ferrazzano, MD
H. James Hamm, MD
Williard G. Huibregtse, MD
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Erie W. Wits, MD
Eugene N. Wright, MD

SMS membership contributions

The persons and organizations named below made contributions to the Charitable, Educational and Scientific Foundation through the SMS membership dues statement from Sept 1, 1991, through Nov 30, 1991.

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Obituaries

David J. Ansfield, MD, 87, a Milwaukee physician for 40 years, died Nov 29, 1991, in Hollywood, Fla. Dr Ansfield was born Nov 11, 1904, in Russia, and graduated from the University of Wisconsin Medical School in Madison. His internship was completed at the UW Hospital and Clinics (formerly Wisconsin General Hospital) in Madison, and his residency was served at the Hospital for Ruptured and Crippled in New York. Dr Ansfield was on the medical staff of Milwaukee County General and Mt Sinai hospitals. He retired from medical practice in 1969 and moved to Florida in 1978. He was president of the Milwaukee Orthopedic Society and Wisconsin Orthopedic Society, and served as vice president of the Clinical Orthopedic Society. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Kay; a son, Paul, of Oshkosh, and a daughter, Mirian, of Bayside.

Leo M. Boxer, MD, 78, formerly of Milwaukee, died Nov 20, 1991, in Boca Raton, Fla. Dr Boxer was born May 2, 1913, in Milwaukee, and graduated from the Marquette University School of Medicine. His internship was completed at St Mary's Hospital in Milwaukee. He served in the US Army Medical Crops from 1941 to 1946. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his son, Robert, of Bayside, and a daughter, Suzanne De Launais, of Brown Deer.

Youssef H. Gabriel, MD, 50, of Rothschild, died Nov 8, 1991, in Wausau. Dr Gabriel was born March 19, 1941, in Egypt, and graduated from the Alexandria University School of Medicine in Egypt. He served a rotating internship in Monmouth Medical Center in New Jersey, and his residency was completed at the University Hospital in Saskatoon, Saskatchewan, Canada. From 1976 to 1979, Dr Gabriel was assistant professor of neurosurgery and lecturer in the Department of Rehabilitation Medicine at the University of Saskatchewan. Dr Gabriel had been on the medical staff of the Medical Center since 1979. He was a member of the Marathon County Medical Society, the SMS, and the AMA. Surviving are his widow, Christine; a son, Mark, and a daughter, Faith, both at home.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.[150th]

Franklin J. Mellencamp, MD, 81, of Milwaukee, died Nov 7, 1991, in Milwaukee. Dr Mellencamp was born Jan 28, 1910, in Ann Arbor, Mich, and graduated from the University of Michigan Medical School. He served his internship at Grace Hospital in Detroit, and completed a residency in pediatrics at University Hospital in Ann Arbor. One of the founding members of the Milwaukee Medical Clinic, Dr Mellencamp also served as chief of staff at Children's Hospital of Wisconsin. He served as a clinical professor of pediatrics at the Medical College of Wisconsin, was president of the Milwaukee Pediatric Society, and a member of the Milwaukee Academy of Medicine. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Ann; two sons, David of Mequon, John, of Haddonfield, NJ; and two daughters, Mary Aspin, of Cornwall on Hudson, NY, and Lucy Gibbons Thibeault, of Marco Island, Fla.

Clarence J. Schneider, MD, 70, of Waupun, died Nov 17, 1991, in Waupun. Dr Schneider was born Oct 24, 1921, in Oshkosh, and graduated from Tulane University Medical School in New Orleans. His internship was completed at Milwaukee County General Hospital. He served with the US Army in World War II and from 1951 to 1953 he was a flight surgeon in the US Air Force serving in Korea. Surviving is his widow, Mary, of Waupun.

Ruth R. Schuh, MD, 69, of Watertown, died Dec 8, 1991, in Madison. Dr Schuh was born Sept 22, 1922, in Manitowoc, and graduated from Marquette University Medical School. She served her internship at Milwaukee County General Hospital. Dr Schuh was a registered nurse and also held a master of public health degree from the University of Minnesota. She had been employed by the city of Milwaukee in the public health department until 1985 and then as a public health officer in Watertown until her retirement in 1989. Dr Schuh was a veteran of World War II service in the South Pacific. She was a member of the Jefferson County Medical Society, the SMS, and the AMA. Surviving are her husband, Dr Eugene; one daughter, Ellen DeMers, of Waukesha; four sons, Paul and Tom, of Watertown, Peter, of Rochester, Minn, and Greg, of Campbell, Scotland.[150th]

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Family practice. Seven doctor multi-specialty clinic in central Wisconsin needs another family practitioner. Outstanding financial package and benefits. Contact Peter McNally or Sean Alwin, MD, Medford Clinic, 101 N. Gibson, Medford, WI 54451; ph 715-748-2121. p2-3/92

Family practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr Paul Hayes' office 906-563-9255 or Dr William Gladstone's home 906-563-8743. Anderson Memorial Hospital, Main St, Norway, MI 49870; 906-563-9243. 2/92

Minnesota. Private practice opportunities in family medicine. Join established clinics with first year guarantees, benefits, and quality management. **Arlington, Eden Prairie, Hopkins, Montgomery, Monticello, Mound, Morris, Wayzata & Grantsburg, Wisconsin.** Contact: Jerry Iless, LifeSpan Hospitals (16501) 800 East 28th St, Minneapolis, MN 55407; 800-248-4921 or 612-863-4193. 2-4/92

SE Wisconsin pediatrics. Join busy pediatric group in prospering community close to Milwaukee, Madison, and Chicago. Rewarding lifestyle, capable colleagues, shared call, first-class hospital with special care nursery. Please contact Kathryn Iorio, MD, Waukesha Pediatric Associates, Ltd, 1111 Delafield St, #115, Waukesha, WI 53188; 414-542-6999. 2-4/92

Pediatrician. BC/BE pediatrician needed for hospital sponsored clinic in midwest metro location with medical draw of one million. Opportunity offers practice management, 6-way call, negotiable guarantee, and optional academics in a community with top rated public schools, colleges, museums, symphony, water recreation, and first class affordable housing. Potential first year income of $150,000+. For more information, mail CV or Call Barb Inselman at 1-800-533-0525, Sherriff & Associates, 10983 Granada Suite 202, Overland Park, Ks 66211. p2/92

Growing, four physician family practice in Oshkosh seeks another associate. Need is dictated by growth in the area and the practice. Each physician sets his own hours and pace and works about 4 1/2 days per week. The group will relocate into a new facility next year. If you enjoy water sports and recreation, Oshkosh is second to none. We also offer museums, symphony, quality schools, and two zoos. We are seeking a residency trained family practitioner who enjoys obstetrics. For complete information, send your CV to Tom Hart, of Harris Kovacs Alderman, 4170 Ashford-Dunwoody Road, Suite 500, Atlanta, GA 30319; or call him at 800-347-7987, ext #1-145. 2/92

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Family practice physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD,MBA, PO box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 1-3/92

Wisconsin. Fourth BC/BE obstetrician/gynecologist needed to join stable, progressive, primary-care based HMO/group practice in University town of 60,000 near Minneapolis/St Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact Stuart R. Lancer, MD, MBA, Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702; 715-836-8552. 1-3/92

Internal medicine physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD, MBA, PO Box 3217, Eau Claire, WI 54702; ph 715-836-8552. 1-3/92

The Wausau Medical Center is seeking board certified/eligible individuals in the following specialties: dermatology, family medicine, gastroenterology, hematology/oncology,

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Physicians Exchange

Continued

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Family practice Wisconsin. Physician needed for partnership in broad based primary care practice in exceptional south central community. Shared call, fully-equipped and staffed office, very competitive guaranteed salary and comprehensive benefit package. For information on this and other opportunities in the upper Midwest, contact and send CV to Mary Jo Cordes, President, MDsearch, PO Box 21507, St Paul, MN 55121 or call 612-454-7291. FAX 612-454-7277. 12/91;1-3/92

General surgeon. Join established lucrative practice serving two excellent hospitals and two county population of 35,000. Peaceful scenic city of 8,500. Excellent housing, school system, shopping, progressive medical staff. Send CV to Jim Schneckloth, 4 Sunset Place, Charles City, Iowa 50616. 12/91;1-2/92

First Care Walk-in medical needs part-time physician (FP,GP,DO) for busy, fee-for-service clinic associated with St Elizabeth Hospital. Competitive salary, flexible hours. Contact: First Care North, F. Svatos, Director, 1225 W. Northland Ave, Appleton, WI 54914; ph 414-738-2005. 12/91;1-2/92

Established, four physician pediatric group seeks 5th practitioner. Practice is full range pediatric/adolescent medicine. Practice is moving to brand new facility next spring. Hospital facilities include 350 beds and level 2 nursery with all specialists and sub-specialists on staff. Community includes many recreational opportunities, especially water sports, quality education–public and parochial, strong economy, numerous museums and symphony. Housing options include many residential lake developments. Financial package includes salary, incentive bonus and relocation allowance. For complete information, send your CV to Tom Hart, of Harris Kovacs Alderman, 4170 Ashford-Dunwoody Rd, Suite 500, Atlanta, GA 30319, or call him at 800-347-7987, ext #1-144. 12/91;1-2/92

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Southeast Wisconsin lakefront community. Urgent care and two family practitioners needed for expanding 37-physician multi-specialty group. Twenty minutes to Milwaukee, one hour to Chicago. Partnership possible within 18 months. Call or write Lee Fivenson, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; ph 1-800-338-7107. p12/91;1-2/92

Urgent care. Busy department in 60 member multi-specialty clinic to add urgent care physician immediately. Excellent salary and benefits. Beautiful southern Wisconsin. Send CV to Dr Stan Gruhn, Riverview Clinic, 580 N. Washington St, Janesville, WI 53545. 12/91;1-5/92

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Physicians Exchange

Continued

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Internist to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, new clinic and constructing new hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. c9tfn/91

Madison, Wisconsin. Positions available: family practice & urgent care (full or part-time). Excellent salary, benefits, lifestyle. Contact Dr John Hansen, Medical Director, Group Health Cooperative, One South Park St, Madison, WI 53715; ph 608-251-4156. GHC is an equal opportunity/affirmative action employer. c5tfn/91

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9-12/91;1-2/92

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Wisconsin. 120 physician multi-specialty clinic in the Fox River Valley of northeastern Wisconsin desires two BC/BE pediatricians to join department of 15 BC/BE pediatricians. Excellent compensation and benefit package, leading to shareholder status after two years. The community offers a superb recreational, cultural, and family environment in which to practice. For information please call or write: Howard Kidd, MD, La Salle Clinic, 411 Lincoln St, Neenah, WI 54956; ph 414-727-4276.
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Contents

March 1992 Vol. 91 No. 3

Opinions

115 *President's page*
The status of the health care financing crisis in Wisconsin
'Medicina nusquam non est' (medicine is universal): X
by Cyril M. "Kim" Hetsko, MD, Madison

117 *Secretary's report*
Every long journey starts with a single, small step
by Thomas L. Adams, CAE

118 *Editorial*
Professor, Professor
by Richard D. Sautter, MD, *medical editor*

Letters

120 Praise for the president's page
by Ralph F. Hudson, MD, Eau Claire

120 WIPRO and the justification of existence
by J.S. Mayersak, MD, Merrill

123 *Soundings*
A moral response to the problems of the medical care system
by Ralph C. Whaley, MD, Barron

Scientific

125 Patient satisfaction with breast reconstruction
by Luke A. Corsten, NA; Sandra V. Suduikis, MD; and William L. Donegan, MD, Milwaukee

130 Acute confusional migraine: case series and review of literature
by O'Neill F. D'Cruz, MD, and David J. Walsh, MD, Chapel Hill, NC, and Milwaukee

Socioeconmic

133 *Public health*
A rationale for universal screening for childhood lead poisoning
by Thomas L. Schlenker, MD, Milwaukee

Organizational

136 *Then, now, and the future*
Highlights from the upcoming annual meeting

138 Nominees for SMS offices: 1992-1993

144 *Notice to members*
Proposed amendments to the SMS constitution and bylaws

147 Vision, imagination, and leadership: William Shainline Middleton, MD, 1890-1975

149 A glimpse into our past
by Richard D. Sautter, MD, *medical editor*

150 Physician briefs

152 IMGs propose changes to section constitution and bylaws

153 County society news

155 SMS members delve into the health care reform debates

Our cover: *Then, now, and the future*-Artifacts from the life of medicine in Wisconsin. See the related article on page 136.

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Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's page

The status of the health care financing crisis in Wisconsin

'Medicina nusquam non est' (medicine is universal): X

Access to the health care system and the cost of high quality care continue to be major issues for Wisconsin and across the country in this election year. Many observers point to significant cost increases and the lack of safety nets, which result in some citizens not being financially able to access the system. Additionally, overall health costs have continued to increase at rates in excess of the Consumer Price Index and 12% of our Gross National Product is attributed to health costs.

A conflict has arisen between the increasing costs of health care and the perception of diminishing resources available to pay for them. Americans want the best and want it now, but want somebody else to pay for it.

How do Wisconsin's current health care and financing systems add up? We most certainly have problems of unevenness of health care as at least seven of 72 counties have no obstetrical services, and the inner city areas of Milwaukee have much higher infant mortality rates. Over the past decade, we have observed the closing of many downtown Milwaukee hospitals, so that now only one remains, and it needs a constant infusion of government funds.

In Wisconsin over the past decade, a number of programs have been developed to control costs, including HMOs, IPAs, PPOs, self-insured ERISA plans, employer buying groups, and various other so-called managed care arrangements.

Recent rapid growth has been noted in the use of self-insurance plans by employers to cover their employees, but under federal ERISA laws such plans are exempt from oversight by the states. These plans are essentially unregulated in terms of benefits offered, fiscal solvency, market conduct, changes in benefits, and payment of claims. These plans are also exempt from contributing to the state's high risk health insurance pool for those who are otherwise unable to obtain health insurance.

For both self-insured plans and state-regulated insurance, cost containment desires have often led to: the elimination from the plan of those with pre-existing conditions; the loss of long-term benefit portability in the event of a job change or a disability; and high premium increases, especially for those with serious health problems.

For physicians, a 600% increase in professional liability insurance costs over the past decade and the costs of defensive medicine brought on by a tort system out of control have further escalated the costs of providing health care.

Nevertheless, physicians need to remember that the business of medicine must never come before the art and science of medicine. We are all subjected to greater public scrutiny because of the greed and excesses of a few in our profession. Wisconsin physicians, it must be noted, have continued their tradition of assuring that no person goes without health care because of financial or other concerns. Programs such as ShareCare, WisconCare, and PartnerCare, participation in Medical Assistance, and the numerous unsung individual acts of compassion and charity stand as testimonial to this. More than 80% of our numbers participate in PartnerCare, which accepts Medicare payments as full payment for care for those over 65 years old and having incomes of less than $19,154.

Cyril M. "Kim" Hetsko, MD

Continued on next page

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In spite of being subjected to a number of undermining forces, the Wisconsin health care system has functioned fairly well-frequently due to the efforts of Wisconsin's physicians. National health statistics have shown Wisconsin to have among the nation's lowest infant mortality rates and longest life expectancies. Insurance industry rankings have rated the overall health of Wisconsin citizens as among the best in the country.

Even a study by the Public Citizen Health Research Group (which advocates a Canadian-style universal health plan) points to Wisconsin as having one of the lowest percentages of uninsured in the country (7%). This rate is even lower than that of the island state of Hawaii, with its universal employer mandate system.

Finally, a recent study by Milliman and Robertson, a New York actuary and consulting firm, ranked the health care costs of 400 of the nation's largest metropolitan areas, based on data from 16 of the nation's largest health underwriters. The clearcut conclusion was that Wisconsin communities have among the lowest health care costs in the country, ranging from Green Bay and Appleton (ranking 399 and 398, with cost at 73% of the national average) to Madison (ranked 324 at 82%) and Milwaukee (ranked 227 at 89%). Five of the 10 communities with the lowest costs were in Wisconsin, and Wisconsin overall ranked as the sixth lowest in the nation. Los Angeles, by the way, ranked No. 1, as the most expensive, at 173%, and many Florida and California metropolitan areas were more than 150% of the national average.

Clearly, we do have problems with health care finances in Wisconsin, and these demand our attention, but we also have an excellent and cost-effective health care system, which, by many measures, leads the country.[15,16]

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Secretary's report

Every long journey starts with a single, small step

Last month, Gov Tommy Thompson and Assembly Speaker Pro Tem David Clarenbach (D-Madison) jointly announced a bipartisan, 7-point plan for health care system reform in Wisconsin. I have written in this space of beginnings before, most recently when the governor announced his support for the small business initiative. The 7-point plan is, then, yet another step down the road to revamping the health care system in Wisconsin. Is it a cure? No, but it is yet another beginning. As much for its coalition character as for its policy changes. And it is not as bad as it could be.

The bipartisan plan includes:

- a 4-year moratorium on hospital construction for additional bed space in Wisconsin;
- a 4-year moratorium on converting existing hospital beds to psychiatric or AODA use;
- a public scrutiny process for proposed new or expanded health care technology;
- a licensing category for rural medical centers;
- prohibition of waivers of deductible and co-insurance provisions by providers, except when the patient's financial hardship justifies such a waiver;
- revision of the mental health and AODA insurance mandate to emphasize alternatives to inpatient treatment; and
- an expansion of the Office of Health

Continued on next page

Thomas L. Adams, CAE

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Supporters of the plan see the moratorium on hospital construction as the key to the initiative's success. The number of hospital beds would be established as the legislation is enacted and projects that have legal, financial or real estate commitments already in place will be allowed to proceed. Under the proposed cap, additional beds could not be added to existing hospitals, although renovation of existing beds would be allowed. New hospitals could be constructed only if they replace existing facilities, and the shifting of beds to satellite hospitals would be prohibited.

Notably, the proposal does not call for hospital rate setting or certificate of need (although there are some in the Legislature who will try to include these via the amendment process), so it has avoided a couple of bad ideas that have been floating around the Capitol lately.

Unfortunately, the bipartisan plan also avoids some of the tougher questions that must be answered before meaningful health care reform can be achieved. The two most obvious are the problems of funding Medical Assistance and the need for medical liability reform. Any dam built that fails to plug these holes will fail to stem the rising tide of health care costs. That's the danger in these sorts of proposals: We must take care that expectations for cost savings are not set too high, for if they are not met–as they *cannot* be with piecemeal approaches–new and stronger pressures for regulation of the health care system will result.

A number of the bipartisan proposals were also found in the 12-point plan formulated by a coalition that included the SMS, the Wisconsin Hospital Association, Wisconsin Association of Life and Health Insurers, Association of Wisconsin HMOs and Wisconsin Manufacturers and Commerce, among others, more than a year ago. Once the media got past the glitz of those who said all we had to do was import a foreign health care system and impose it on all of America, the 12-point plan began to pick up support from many sectors. So, without getting over excited, there is reason for optimism.

One of the strengths the 7-point plan and 12-point plan have in common is their coalition character. Although the 7-point plan can be criticized as heavy on the cost concerns and light on concerns of health care quality and access, the fact that it has a bipartisan origin and bipartisan support is a good sign. It is only through shared responsibility and shared effort that an equitable and workable solution will be found.

Wisconsin's physicians, of course, still have work to do. First, we have to nurture that spirit of cooperation. Second, we have to spend the weeks between legislative sessions talking to anyone who will listen–particularly, peers, opinion makers, community leaders and elected officials–about our options for change. With this coalition effort, we have, I believe, taken the first step on our long journey. 150th

Editorial

Professor, Professor

I was listening to a talk show featuring J. Roger Hollingsworth, professor at the University of Wisconsin, and he was discussing his ideas on how to cure the American health care system. The only new concept aired by this quaint professor was the comparison of the financing of health care to the financing of education.

He indicated that in such a plan he would be paid a fee for recommending books to students, giving tests, conducting teaching sessions, giving lectures and so forth. One has to wonder what the hell he does now other than hold court on public radio.

The obvious comparison, of which he did not speak, was how many hours of work were involved. I am afraid the dear professor wouldn't be able to work his 20-hour week or take a year off every 7 years, or have the time to write books (which I am sure his students must buy), if he followed a physician's work schedule.

I am more than a little weary of blue-eyed, intellectual booby-birds giving advice on how to fix the health care system when they so obviously have little, if any, knowledge of what is truly involved in taking care of a sick patient.

So, J. Roger please find a subject on which you have a modicum of actual experience. Return to your throne in some hallowed hall and write a book on the history of what students do when they find they cannot cut it in the hard sciences. Sociology, perhaps.

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Letters

Praise for the president's page

To the editor: I will not allow procrastination to take its toll on good intentions. This note is long overdue and prompted by your comments in the December issue of the *Wisconsin Medical Journal.* As the winds of change swirl around us, you did a superb piece of writing to summarize the role of the complete physician. I have heard it said that we wouldn't face such uncertainties if we had for years shown the involvement with people and community which you encourage. Indeed, one of my concerns about public image has been that too often, organized medicine has been seen as reactionary and protective of physicians' incomes and position rather than as champions of caring and concern. Remember, I'm not taking down you, myself, or our colleagues who exemplify the best–but I am simple reflecting what seems to be the perception.

In our area of the state, I have seen some of the antiquated berating of the "socialized medicine" issue–that somehow the involvement of government will make us slaves. My response: If you feel like a slave, I guess you are one. If you think of yourself as a physician, I guess you can be one in almost any system. I'm certainly not a flaming liberal, but I do think that the AMA and other representatives of physicians have to listen to patients and this at least includes a consideration of single-payer plans to avoid the morass of insurance contracts. I sense in you an open individual. Keep up the good work!

–Ralph F. Hudson, MD
Eau Claire

WIPRO and the justification of existence

To the editor: Any physicians in the state of Wisconsin initially participated in WisPRO when the function of the organization was to initiate physician education to promote improvement in the delivery of medical care. With the arrival of WIPRO on the scene, the regional concept of the physician education was lost, but has degenerated from the WIPRO initial concept of physician education and now represents an abhorrent and ludicrous effort at cost control and justification of one's existence.

The vast majority of qualified and responsible physicians in Wisconsin have all had a WIPRO sanction for one ludicrous reason or another. It quickly became evident to all the physicians involved that the sanctions were cost control in effort and that any concern for quality of care was secondary to the cost control.

Even more disturbing, however, is the fact that with the reduction in WIPRO's budget, there has been a concerted effort by those in control of WIPRO to justify their continued existence. No longer are the sanctions being initiated by WIPRO on the basis of quality concerns or, for that matter, cost concerns, but primarily on the basis of WIPRO demonstrating the usefulness of their existence to the federal government.

One point quality concerns are as abundant as leaves on a tree. The initial evaluation of the charge is accomplished by a "nurse coordinator." The WIPRO concerns with their point deductions are sent to the physician many times, I am sure, without a physician even seeing why they are being sent. Physicians have been bringing these irresponsible quality concerns of WIPRO to the peer review committees of their hospitals, and the ludicrous nature of these concerns is so evident that one can only accuse WIPRO of "churning" their results.

As WIPRO now stands, it represents nothing more than an organization doing

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its very best to justify its existence to the federal government by finding "quality concerns" that are nonexistent.

It is imperative that the SMS leadership recognize the problems with WIPRO and demonstrate their inefficiency to the powers that be. Hopefully, the SMS leadership will include in their mailing of their monthly information sheets to the physicians a ballot which would indicate whether or not the physician feels that WIPRO is of any use or represents just another quasi-judicial organization of the government struggling invaliantly with sincere effort to maintain their justification for existence.

A lot of individuals are being paid good money for functioning in this organization, and they certainly have a sincere reason to make sure that the organization persists in its existence. The cost and extreme waste of money associated with this organization is a crime. This money could be much better spent for health care in Wisconsin than for individuals to maintain their existence by finding nonexistent quality concerns.

–J. S. Mayersak, MD
Merrill 150th

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Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported, it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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Soundings

A moral response to the problems of the medical care system

Ralph C. Whaley, MD, Barron

THE PRINCIPAL CONTENTION of those who complain about health care in the United States is that it is too expensive. So expensive that many who need care can't afford it. The most vocal of critics of our system believe that every human is entitled to health care services as a consequence of his existence. This belief has motivated and energized the proponents of socialized medicine in our country. They had little success until the Medicare law was implemented in 1966. The concept of taxpayer funding of medical care for those judged indigent by a specific standard was already in place, but the Medicare program specifically excluded the poverty requirement to receive services funded by taxpayers.

When people are offered something they view as desirable at no direct cost to themselves, their demand for it grows rapidly. The overall cost of medical care under the programs cited grew rapidly and continues to grow. The response of the proponents of these programs has been to impose a blizzard of regulations to reduce demand and lower payments. The critical thinker notes that this response is a rejection of the premise justifying the program in the first place–that is entitlement as a function of one's existence.

This blizzard of regulations is exemplified by the limitation of entitlement to "essential health care" or "basic health care" needs, but without any definition of what is essential or basic to whom or in what circumstances. The blizzard also includes the tyranny of government price fixing–setting prices for services to manipulate and control what providers do and under what conditions and circumstances they may do them. The penalties for violations are severe and frightening to the providers. The natural response of providers is to pay very close attention to their primary work. The long term consequences of such interaction is destructive and devastating.

So what are we to do? To formulate a rational course of action we must first understand the nature of things and man's nature in particular. I start with three postulates paraphrasing in part those stated by the brilliant philosopher Ayn Rand: 1) existence exists; 2) man exists; and, 3) man is a specific entity with characteristics which all entities we know as man possess.

Identification of the defining characteristics was stated in part in the Declaration of Independence. "We hold these truths to be self-evident that all men are created equal (they all have characteristics in common which enable us to iden-

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tify them as human), that they are endowed by their Creator with certain inalienable rights, that among these are life, liberty, and the pursuit of happiness." It is very important to note that a man has a right to his own life and not that of another man.

Human life has essential requirements for sustenance and these may only be acquired by human effort. To obtain these essentials for continuing life, only three options are available: 1) They may be earned by the productive work of the individual for himself; 2) they may be received as a gift from another human whose effort produced them; and 3) they may be taken by force from the one who produced them and used by the taker or delivered to another person by the taker.

It is clear that Option 3 contradicts Postulate 3 since this action subjugates the producer to the taker and thus denies their equality as humans entitled to life, liberty, and the pursuit of happiness.

The solution to the problem posed at the outset is the economic system of capitalism which embodies and is congruent with the nature of man. It is the system by which humans exchange value for value by mutual agreement reached by persuasion only–no physical force allowed. The characteristics of the transactions are agreed to by mutual consent including the price due the vendor from the purchaser and the nature of the good or service to be delivered to the consumer or purchaser. Whatever the dollar amount of such transactions individually or in total is always exactly the right amount by virtue of mutual consent of the parties involved. This is the implementation of Option 1 for sustaining human life. Gifts from loved ones, relatives, those who care for a person unable to provide for his own needs or wants is the only moral alternative to Option 1.

When you consider the current state of our nation and specifically the medical care system, you will see that the problems are the unavoidable consequences of the philosophies of collectivism and altruism which hold that men are not equal in their humanity. Altruism and collectivism require at minimum two classes of humans–those who are needy and unable or unwilling to provide for themselves who are entitled by virtue of their existence to the satisfaction and fulfillment of those needs and another class of humans who are capable, productive, and affluent. This philosophy further holds that a primary role of government is to take from the affluent that which the first class needs and distribute it to them. The inevitable consequence of accepting this philosophy is a contest to achieve neediness and a tyranny which steals that which men produce to distribute to the winners of the needs contest. Productive men hide from the tyrants.

When you consider proposals and analysis at this conference, ask yourself, do they contradict the nature of man? Do they rest on the premise of at least two classes of humans? Do they meet the test of the two acceptable moral methods of fulfilling the requirements for sustaining human life? Altruism, collectivism, the social welfare state these concepts are the cause of the health care problem. They must be rejected. "Capitalism" is the solution!150th

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Patient satisfaction with breast reconstruction

Luke A. Corsten, BA; Sandra V. Suduikis, MD; and William L. Donegan, MD, Milwaukee

Thirty-two women were surveyed to assess their satisfaction with breast reconstruction after mastectomy for cancer. Most reconstructions consisted of a submuscular implant, and were performed after an average interval of 11.3 months. The procedures averaged 2.4 per individual, and nearly half of the women reported requiring an operation on the opposite breast to attain symmetry. Despite the fact that 60% of the reconstructions resulted in a complication or complaint, women reported that they felt more balanced and whole and less depressed, and all were glad that they had breast reconstruction. *Wis Med J.* 1992;91(3):125-129.

Breast reconstruction has seen significant advances in surgical technique in recent years. The advent of the modified radical mastectomy facilitated these advances, and numerous reconstructive techniques have been developed. Increasing numbers of women are choosing to undergo breast reconstruction after mastectomy, and the object of this study was to evaluate the success of reconstruction from the point of view of the patient. The data were gathered by a survey of patients who had reconstruction.

Dr Donegan is a professor of surgery at the Medical College of Wisconsin in Milwaukee. Dr Suduikis is a fellow in brain injury rehabilitation at Tufts University School of Medicine in Boston. Corsten is a junior medical student at the Medical College of Wisconsin. Reprint requests to: William L. Donegan, MD, Department of Surgery, 950 N 12th St, Milwaukee, WI 53201. Copyright 1992 by the State Medical Society of Wisconsin.

Patients and methods

The records were reviewed of 237 consecutive patients who underwent mastectomies between 1981 and 1991 by one surgeon (WLD) in Milwaukee, Wisc. Thirty-two of these patients (14.3%) had breast reconstruction. The reconstructions were performed by plastic surgeons at several hospitals in the community and at varying periods after mastectomy. None were immediate. Six women had bilateral reconstructions.

Questionnaires were mailed to the women. The questions addressed four areas: 1) general information such as marital status, employment status, and type of reconstruction; 2) the patients' satisfaction with the results; 3) the impact of reconstruction on the patients' psychological well being; and 4) complications or complaints. In addition, the patients were encouraged to write comments throughout the body of the questionnaire.

Results

Thirty of 32 patients (94%) completed and returned the questionnaires; one patient was deceased. The time between mastectomy and reconstruction ranged between 3 and 36 months with an average of 11.3 months. The average age of the patients was 47 years; 23 were married, three were single, and four were divorced. Eighteen were employed at the time of mastectomy. Three women reported having to change their job duties and two reported having to quit their jobs because of their mastectomies.

Figure 1 shows the types of reconstruction reported. Combining all categories, 80% had implants, 8% of which were combined with myocutaneous flaps, and 20% had transverse rectus abdominous myocutaneous (TRAM) flaps. Nineteen patients (63%) had nipple reconstruction, and five patients (17%) reported they were planning it. Of the six patients (20%) who did not have nipple reconstruction, three reported not wanting to undergo further surgery as a reason, and a reconstructed nipple as not being important was reported five times. Cost was a consideration for only one.

The average number of operations,

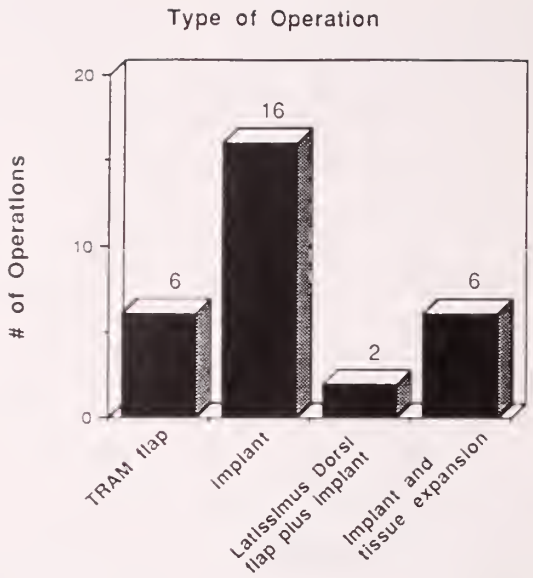

Fig 1.–Thirty breast reconstructions and the number of women that had each type.

both for those who did and did not have nipple reconstruction, was 2.4. Fourteen women (47%) reported that they required operations on the opposite breast in order to attain symmetry with the reconstructed breast.

Figure 2 shows complications and complaints. Ten patients reported no problems. The "other" category includes significant scarring at the incision sites, pubic hair growth on the reconstructed nipple, an inguinal hernia from a TRAM flap, loss of range of arm motion on the reconstructed side, and shrinkage of the reconstructed breast. Five of the 24 reconstructions using implants (21%) resulted in capsule formation. No attempt was made by the authors to confirm complications independently.

Despite complaints, patients were unanimous in that: 1) they were glad they underwent reconstruction; 2) they would undergo it again if they had to; and 3) they would recommend it to someone else with a mastectomy. When asked if breast reconstruction made their life better, 20 women (67%) reported that it did, and the remaining 10 (33%) reported no change.

Women were asked to rate a list of motivations for having breast reconstruction. The three reasons most often mentioned were (in descending order) "to feel more normal" (25), "to be rid of my external prostheses" (17), and "to be able to wear more types of clothes" (14).

Of 29 responses to questions about the effects of reconstruction on relationships with mates, 18 (62%) said their overall relationship was the same after reconstruction as it was before, three (10%) said it had improved, and one patient (3%) said it was worse after reconstruction (although not caused by her mastectomy or reconstruction). Fourteen (64%) of 22 women who answered the question about sexual relationships reported that they remained unchanged, six patients (27%) reported that it became better, and two (9%) reported that it became worse.

The total cost of reconstruction according to patients varied greatly; a distribution is shown in Figure 3. Six patients were unsure. All patients had at least partial coverage, either by private health insurance or by Medicare. Fifteen patients (50%) had full coverage by private health insurance.

Discussion

It is difficult to quantify patient satisfaction; our data are largely subjective. The weaknesses of this study include small sample size and any bias inherent in the practice of one general surgeon. It does provide, however, insight into women's perceptions about the desirability and results of reconstruction based on personal experiences.

The psychological effects of mastectomy and breast reconstruction are well known.[14] The primary motivators for re-

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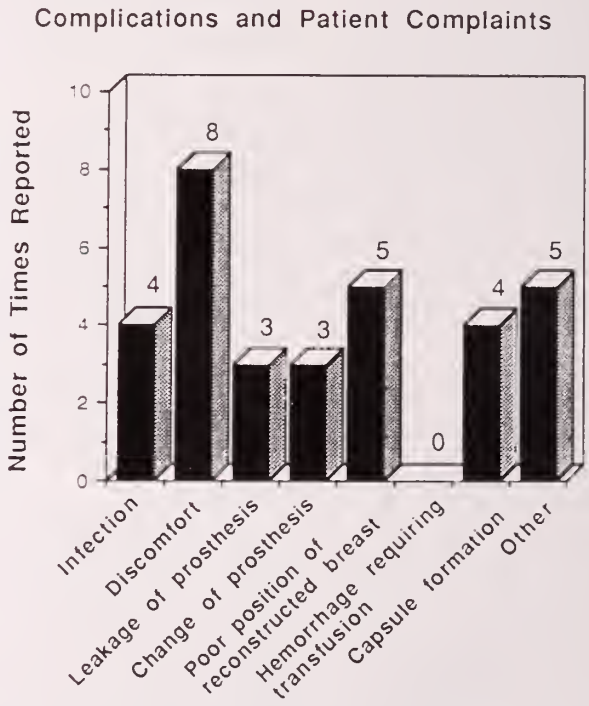

Fig 2.–The frequency distribution of the complications or complaints reported by 30 women with breast reconstructions.

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Continued from page 126
construction found in this study, ie, "to feel more normal," "to be rid of my external prosthesis," and "to be able to wear more types of clothes," were listed by Schain et al, in 1985.[5] The effects of reconstruction on marital and sexual relationship were not significant. Kincaid, citing a book by Weatherly-White (1980), noted that reconstruction is more strongly motivated by a "primary desire" to improve one's self image than a concern about "how it will affect others, including mates."[6] In 1988 it was also noted by Dean that "it appears that the patient's marital relationship is not often adversely affected and can actually improve following mastectomy."[4]

While there are now numerous techniques of reconstructing the breast, the majority of reconstructions in this study consisted of submuscular implants. Tissue expansion and TRAM flaps are more recent innovations, as is immediate reconstruction at the time of mastectomy. We observed that TRAM flaps, although few in number, had a relatively high rate of success, with four of six operations (67%) resulting in no complaints. The 24 reconstructions that used implants had a comparably high rate of complaints. On the average, however, the TRAM flaps required more operations than did the submuscular implants. Fibrosis and contraction of tissues around implants (capsule formation) is undesirable as it makes them feel discrete and firm. The rate of capsule formation found in this study (21%) is consistent with a recent study from Sweden; comparing silicone gel and saline-filled implants, Gylbert et al, reported that 16% of the saline-filled and 50% of the silicone gel implants resulted in capsule formation.[7] Gradual loss of saline from implants over time can result in wrinkling or deflation of the implant, and, rarely, silicone gel can leak causing a severe tissue reaction. It is important for information to be available about the risks associated with the various procedures. Breast reconstruction is complicated and should not, as Kincaid has noted, be "presented as a simple operation with uniformly good results."[5]

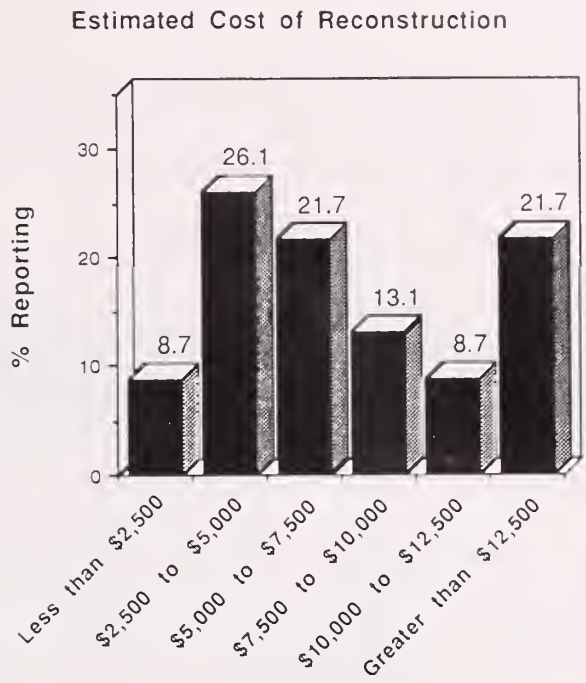

Fig 3.–The frequency of the cost of breast reconstruction as reported by 24 women; six women reported that they were unsure of the cost.

A recent survey of 86 general and plastic surgeons reported an average reconstruction rate of 19%;[8] we found a rate of 13.5%, which is comparable considering the small sample size. The 45 responding surgeons judged the results very good in 18%, good in 42%, only fair in 20%, and variable in 4%.[8] We did not independently evaluate aesthetic results.

We found that reconstruction did make a significant difference in the patients' feeling about themselves. While many women who require mastectomy do not choose reconstruction, it is an important option. The reports of feeling less depressed, more balanced and whole, and more feminine, were expected.[2,3,5] None reported feeling more depressed or regretted that they had reconstruction. The improvement of physical or sexual attractiveness was often reported as important, but did not appear to be a primary motivator. Schain et al noted,[5] that "an external breast prosthesis is never incorporated into a woman's body image," and herein lies the value of breast reconstruction.

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Acute confusional migraine: case series and review of literature

O'Neill F. D'Cruz, MD, and David J. Walsh, MD, Chapel Hill, NC, and Milwaukee

Acute confusional state (ACS) as a manifestation of migraine in the pediatric age group was initially described by Gascon and Barlow.[1] The characteristics and natural history of acute confusional migraine (ACM) have been elaborated on by other authors.[2,3] The diagnosis of ACM is, however, easily overlooked in clinical practice, due to its peculiar presentation. We describe three children who had acute onset of confusion. The differential diagnosis of acute confusional state and the clinical features and management of ACM are discussed. *Wis Med J.* 1992;91(3):130-131.

Case reports

Case 1. An 11-year-old girl was admitted to the hospital with a history of acute onset of throbbing headache and emesis. Confusion, disorientation, and slurred speech were observed during this 4-hour episode.

There was no history of fever, head trauma or substance abuse. A family history of maternal migraine headaches was elicited. The girl reported occasional previous headaches although these were not associated with other symptoms. She remembered the onset of headache and emesis, but was amnesic for other details of the event.

On examination, her vital signs were normal, as were the results of general and neurologic examinations. Chemistry panel, toxicology screen, and CSF studies were unremarkable. CT of the head did not reveal any abnormalities. An EEG was remarkable for intermittent slowing in the left occipital region.

The patient was alert and free of symptoms the next morning. She was discharged and had no recurrence of episodes over the next 6 months.

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Case 2. An 11-year-old girl was admitted with acute onset of nausea and inferior visual field scotomas, followed by a throbbing headache, disorientation, and unsteady gait. Her speech was slurred, she was unable to comprehend simple directions, and she repeatedly asked the same questions.

There was no history of trauma, toxic ingestion, or febrile illness. Both parents suffered from migraine headaches.

The episode ended spontaneously after 6 hours, with sleep ensuing. The next day, the patient had partial amnesia for the episode. Results of a neurologic examination were unremarkable. Results of chemistry panel and CSF studies were normal. The results of a toxicology screen were negative. CT scan of the head revealed no abnormality. An EEG showed intermittent posterior slowing. The episodes did not recur during the following 6 months.

Case 3. An 11-year-old girl developed acute onset of a throbbing headache, nausea, and bilateral visual scotomas. She was also disoriented and confused during this time, being unable to talk or follow directions. Her medical history was remarkable for a liver transplant for biliary atresia. The patient was on multiple medications including cyclosporine A, Imuran (azathioprine), prednisone, acyclovir, aspirin, and Procardia (nifedipine). Family history was remarkable for headaches in the patient's mother and brother. There was no history of seizures, fever, recent infections, or migraine headaches. Two days prior to the acute episode the patient had sustained closed head injury without loss of consciousness or other neurologic symptoms. The episode lasted about 6 hours and subsided spontaneously with the onset of sleep.

On admission, the patient was alert but could not recall details of the episode. Her BP was 180/112. She was afebrile and not in distress. The BP normalized with antihypertensive treatment. The results of a neurologic examination, including fundoscopy, were normal. Her CBC count, chemistry panel, and results of CSF studies were normal. A head CT revealed no abnormality. Cyclosporine A levels measured at 580 ng/ml. An EEG revealed diffuse slowing most prominent in the occipital area.

Discussion

Acute onset of confusion has been reported in a variety of conditions, including migraine,[1] head trauma,[4] nonconvulsive status epilepticus,[5] and cerebral infarction.[6] In addition, hyperpyrexia, CNS infection, and toxic metabolic encephalopathy may also produce a similar picture.[7] The history, physical examination, and initial workup should address the above mentioned causes.

The diagnosis of acute confusional migraine is usually made after the acute episode has subsided. The majority of reported cases occurred in adolescence.[5] In one series,[5] 75% of patients had a family history, and 83% had a personal history of migraine headaches. Head trauma may precipitate the acute episodes.[2,8]

Acute episodes can occur as the initial manifestation of migraine. The attacks may last several hours and are associated with agitated confusion.[5] A headache may precede, occur simultaneously with, or follow the period of confusion. Visual difficulties and confusion, rather than a headache, may be the primary symptoms of an acute episode. Focal neurologic deficits may be noted during the attacks, but they usually resolve within 24 hours. Results of CSF studies and CT scans are normal. EEG recordings during the attacks show diffuse or focal slowing of

background activity, as well as frontal intermittent rhythmic delta activity.[5] The attacks typically resolve with sleep. The patient may have partial or total amnesia for the episode.

The treatment of the initial acute episode is usually limited by the difficulty of making a conclusive diagnosis. In addition, the episodes tend to resolve spontaneously, usually with sleep. Sublingual ergotamine is reported to be of some benefit in acute attacks,[2] and may be useful if episodes recur. If the patient has a personal history of recurrent migraine headaches, propranolol, amitriptyline or cyproheptadine may be used as migraine prophylaxis.

Acknowledgement
The authors thank Susan Hoffman for assistance with manuscript preparation.

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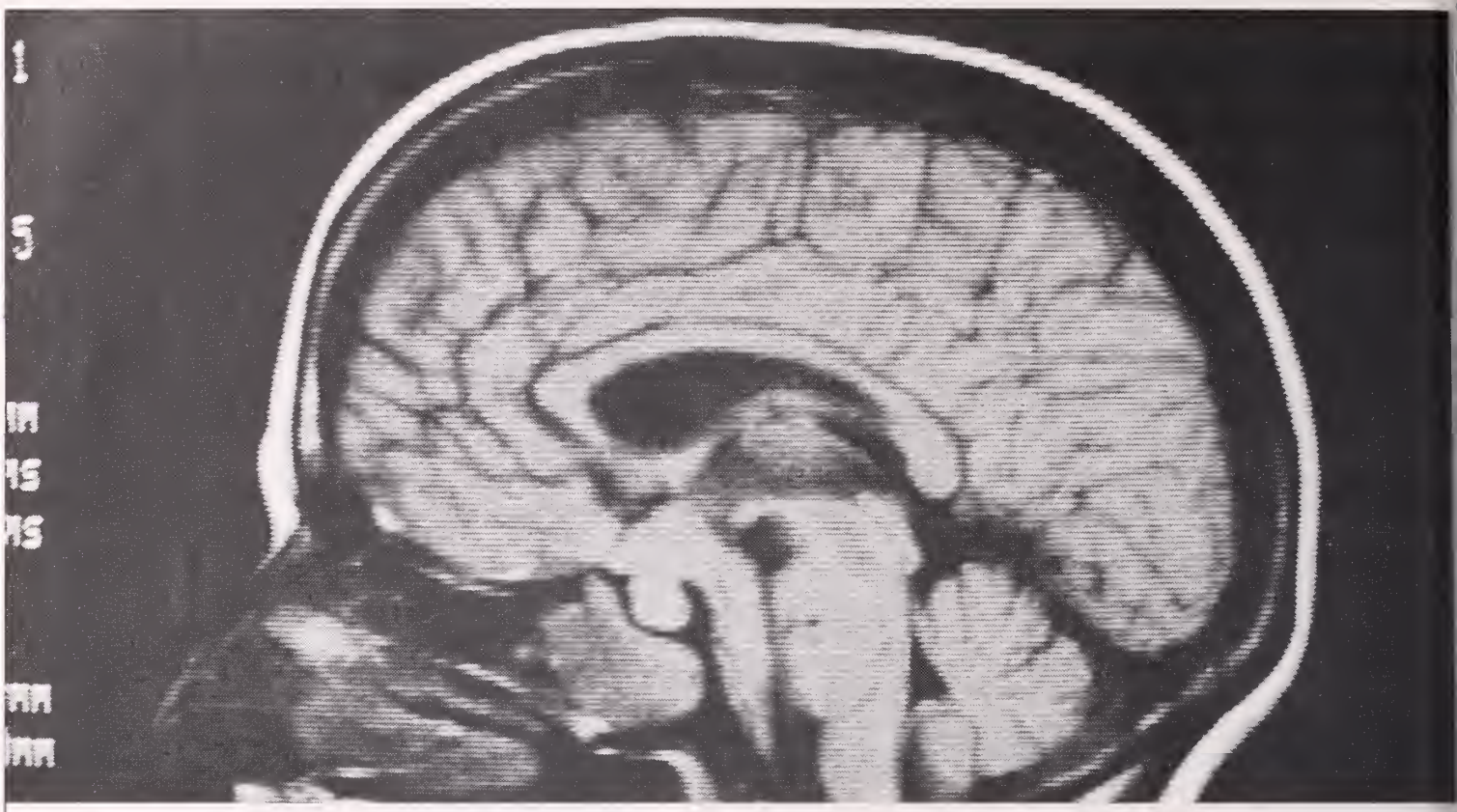

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Public health

A rationale for universal screening for childhood lead poisoning

Thomas Schlenker, MD, Milwaukee

Screening all age-appropriate children in the United States for lead poisoning has recently been established by the Centers for Disease Control (CDC) as a national goal and a standard of care for practitioners.[1] This population-based universal screening policy raises both theoretical and practical considerations that merit informed discussion among physicians who care for children.

Screening in the practice of medicine means the application of standard diagnostic tests to entire populations of well individuals to detect, by definition, hidden disease. This contrasts with the use of diagnostic tests on individuals who, in some way, indicate that they might be ill. Population-based screening for childhood lead poisoning implies testing all children 6 months old through 6 years old for blood lead at least once, preferably twice and in some cases repeatedly.

Screening is an accepted routine practice in the United States for many different diseases. Papanicolaou smears for cervical cancer and stool heme tests for colonic cancer are the standard of care for age-appropriate adults. The American Academy of Pediatrics advocates a routine screen for anemia for all children 1 and 5 years of age. The CDC recommends hepatitis B serological tests for all pregnant women. All newborns in the United States are currently screened with blood tests to rule out several serious congenital diseases.

In contrast, other proposed routine, population-based screening tests are rejected by most authorities. Routine chest roentgenograms to screen for cancer of the lung, routine urinalysis for bacteriuria in women, blood tests for the cystic fibrosis gene and HIV testing when proposed for people without apparent sign of illness or risk factors are generally considered inappropriate. On what basis should the decision to screen or not to screen be made? The following are offered as appropriate criteria for population-based screening.

Criterion 1

Is the disease in question a serious one? Lead poisoning in children is known to cause serious and permanent damage to the central nervous system. Even at low levels of exposure, learning and behavioral disabilities and reduced intelligence can result.[2-4] Needleman's long term follow-up study showed that lead exposure in early childhood multiplies an individual's risk of failure in school.[5] Moreover, high level lead poisoning (>70 ug/dL) still occurs and can result in severe acute illness, lasting profound neurological deficit and even death.[6,7]

Criterion 2

Is the disease in question sufficiently common? It is estimated by the CDC that 17% of all US children (3 to 4 million) have blood lead levels ≥15 ug/dL.[8] In Milwaukee, a random survey of an average private pediatric practice revealed 22% of 6-month to 6-year-old patients had lead levels ≥15 ug/dL and 3% were ≥25 ug/dL.[9] This prevalence of lead poisoning (≥25 ug/dL) is approximately 400 times that of cystic fibrosis, the most common serious genetic disease in the United States, and 1,200 times the prevalence of hypothyroidism, the most common of the serious congenital diseases currently being

Continued on next page

Dr Schlenker is the special deputy commissioner and medical director of the Milwaukee Health Department. The Milwaukee Health Department's lead poisoning screening program is supported in part by grant #H46/CCH506537-01 from the Centers for Disease Control to the Wisconsin Division of Health. Reprint requests to: Thomas L. Schlenker, MD, 841 N. Broadway, Room 112, Milwaukee, WI 53202. Copyright 1992 by the State Medical Society of Wisconsin.

Continued from preceding page
screened for in newborns. In many populations of infants and toddlers, lead levels above 15 ug/dL will be more common than anemia.

Criterion 3.
Is an adequate screening method available?

A. Safety: Blood samples for lead measurement, whether finger-stick or venipuncture specimens, can be obtained essentially without risk.

B. Practicality: Venipuncture on young children can sometimes be quite difficult. Finger-stick or heal-stick procedures, on the other hand, are easy and a routine part of almost every pediatric practice.

C. Cost: The Milwaukee Health Department Laboratory and the Wisconsin State Laboratory of Hygiene currently charge $13 for a blood lead measurement.

D. Validity: Although lead levels performed on venous blood specimens of 4 to 5 mL are the gold standard, microspecimens obtained by properly performed finger-stick procedures have shown excellent correlation with simultaneously drawn venous blood leads. Finger-stick leads are very sensitive, ie few elevated venous blood lead levels will be missed by using the finger-stick method in its place. This is in contrast with the old erythrocyte protoporphyrin (EP) test which missed from 25% to 75% of all truly elevated blood leads.[10]

Also, unlike EP, finger-sticks are relatively specific. False positives are a function of skin contamination secondary to improper technique and can be held to a minimum by diligent technicians. A Milwaukee Health Department pilot finger-stick study using hand washing with soap and water followed by a dilute nitric acid rinse performed by well trained staff yielded no false positives when compared with simultaneously drawn venous leads.

Criterion 4
Once disease is uncovered, can remedial action be taken that will have a significant positive effect on the outcome? Most elevated lead levels uncovered by screening will be on the low end of the spectrum (between 15 and 25 ug/dL). At these levels, education by the physician on the danger of lead poisoning, sources of lead in the home environment and interventions to eliminate exposure can prevent further damage to children's health. No good studies quantifying the effectiveness of education received in physicians' offices are yet available. Nevertheless, knowing the consequences of lead levels ≥25 ug/dL in early childhood, we are obliged to try. Establishing each age-appropriate child's blood lead level is key. General anticipatory guidance on lead poisoning offered by physicians to families without benefit of blood levels would necessitate a diluted message and would not allow physicians to target their time and effort where it is most needed. In addition, the receptiveness of parents to education must be assumed to be heightened when their child has been identified as lead poisoned.

For children with lead levels above 20-25 ug/dL, many cities and states offer nurse case-management and services to inspect households for lead hazards and enforce abatement. This is a important complement to physician education and it is hoped that stringent abatement standards and aggressive enforcement and follow up will ensure that lead exposures are reduced and most poisoned children quickly be restored to tolerable body lead burdens. The effectiveness of such a three part program is yet to be quantified but again, we are obliged to intervene on behalf of this population of children in urgent need. Similarly, we are obliged to evaluate the effectiveness of all programs to ensure the outcome we desire.

For children with lead levels above 45-50 ug/dL, prompt chelation therapy is standard practice.

Criterion 5
Is the cost of screening and intervention reasonable in relation to the benefit of preventing the disease? According to the CDC, average avoidable costs (medical, special education and life time lost earnings) for each case of lead poisoning above 24 ug/dL are $16,101.[11] In 1991 in Milwaukee, we have screened about 8,000 children with a case finding rate (prevalence) of about 5% (400 children >24 ug/dL).

Each blood test for lead costs $13. We estimate we may spend $1,000 managing each "case." The total costs of screening plus the public health intervention program would thus be $504,000 ($13 X 8,000 + $1,000 X 400) as compared to the total costs avoided through prevention $6,440,400 ($16,101 X 400). Assuming that the interventions undertaken are successful, the cost-benefit ratio of $504,000 spent over $6,440,400 saved, means $12.78 is earned for every $1 spent. Even if the costs of repair of household lead hazards, which are borne by the property owner, were factored in the resultant cost-benefit ratio would still weigh heavily toward intervention.

The prevalence of lead poisoning in a population will impact on the cost-benefit ratio of screening. Milwaukee's prevalence of 5% yields a ratio of 1:13. A prevalence of 1% would yield a ratio of 1:7. A prevalence of 0.5% yields a ratio of 1:4.5. The cost- benefit ratio ceases to be greater than one only when the prevalence dips below 0.1%. Therefore, screening pays off (in a purely economic sense) in any community with a lead poisoning prevalence of 0.1% (1 per 1,000) or more.

Although the money saved by preventing a case of lead poisoning and the money spent on public health intervention are estimates, the approximate cost-benefit ratio they yield provides a useful framework to judge the purely fiscal appropriateness of universal screening. In general, only if lead poisoning were an extremely rare disease, which it is not, would it be cost-efficient not to screen for

Series coordinators
The Wisconsin Division of Health's Patrick Remington, MD, and Henry Anderson, MD, are coordinating this series for the *Wisconsin Medical Journal*. This series is intended to help inform physicians on public health policies and considerations. The public health series is not reviewed by the *WMJ* Editorial Board.

it in at-risk populations. The non-monetary rewards, however, (ie, the health of children and their future contributions to society) clearly also must be added into the equation.

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Then, now, and the future
Highlights from the upcoming annual meeting

WHERE DO WE STAND? What new technologies are on the horizon? What can we do differently or better? How can we prepare to meet the challenges of the future?

Those are some of the tough questions facing Wisconsin physicians. SMS members will tackle the issues, debate the possibilities and develop solutions when the medical society's 1992 annual meeting convenes this April in Milwaukee.

"Then, Now and the Future," the 1992 SMS annual meeting and 150th anniversary observance, offers SMS members a chance to become more involved in their medical society, to continue education through scientific seminars and to get to know physicians with common interests and concerns. The meeting will be held April 22-25 in Milwaukee at the Hyatt Regency Hotel, 333 W Kilbourn, and the MECCA, 500 W Kilbourn.

As the theme suggests, the purpose of the 1992 annual meeting will be threefold. As the SMS celebrates its seisquicentennial, we will take a look back at the myriad contributions of Wisconsin's medical pioneers. We will explore the problems and possibilities of the present. And we will embrace the challenges and opportunities of the future.

Here are some highlights from the agenda:

Celebrate 150 years of caring

Wisconsin's pioneering physicians broke trail for what has proved to be a lasting legacy of caring, compassionate and high quality health care for citizens of the Badger State. Join us as we take a look at some of these medical pioneers and celebrate the contributions of physicians across the state and through time.

Discover how history has shaped medicine and take a journey into the future of medicine with a special SMS plenary session featuring Earl Thayer, Rep Frank Urban, MD, and keynote speaker G. Gayle Stephens, MD, of Birmingham, Ala.

Explore the present

The 1992 SMS annual meeting offers you an unique opportunity for involvement. Invest in your future by joining in the discussions and debates of major policy questions facing Wisconsin physicians. The SMS House of Delegates will convene Wednesday, April 22, at 4 pm in Milwaukee. Talk to your delegates about your concerns. Any member may speak at the reference committees. Make your voice heard by attending these important events!

Meet your new president. William J. Listwan, MD, of West Bend, will be sworn in as the next SMS president on Thursday, April 23. Join current SMS President Cyril M. "Kim" Hetsko, MD, in welcoming Dr Listwan at a very unconventional SMS inaugural reception sure to please any adventurous spirit!

Connect with your peers. Write yourself a well-deserved prescription for relaxation and fun. Get to know other SMS members and renew old acquaintances.

Enjoy the following special attractions:

- The 1992 WISPAC reception featuring Washington, DC, comedienne Joan Cushing. Spend an evening with the entertaining "Mrs Foggybottom."
- Specialty luncheons and dinners
- Young Physician Section beach party
- SMS exhibit hall–see the latest offerings from a broad spectrum of firms specialized in serving physicians' needs.

Attend special presentiations. Arnold Greensher, MD, from the University of Colorado, will present "Prenatal Care: A Systems Approach. Eliminating Obstetrical Malpractice Risk." The special presentation is sponsored by the Physicians Insurance Company of Wisconsin.

Embrace the future

The challenges of new technology surround you. The SMS invites you to take an active role in meeting the health care challenges of the future. The 1992 annual meeting offers you an outstanding curriculum of scientific seminars. Join your colleagues in embracing what the future holds for medicine.

Participate in scientific seminars. The

Continued on next page

Continued from preceding page
following specialty societies have scheduled scientific programs in conjunction with the 1992 annual meeting:

- allergy,
- anesthesia,
- dermatology,
- internal medicine,
- orthopaedic surgery,
- otolaryngology,
- pathology,
- physical medicine,
- plastic surgery,
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- J. David Richardson, MD, of Louisville, Ky. Topic: occult gastrointestinal bleeding.
- J. Michael Murphy, MD, of the Mayo Medical School. Topic: perioperative management of the patient with cardiovascular disease for non-cardiac surgery.
- James Arnold, MD, of Case Western Reserve University. Topics: midfacial tumors in children and velopharyngeal insufficiency.
- Denise Buntin, MD, of the University of Illinois. Topic: update on sexually transmitted diseases.
- Gary Rachelefsky, MD, of the UCLA School of Medicine. Topics: the role of sinusitis in asthma and patient education in asthma treatment.

Who should attend the 1992 SMS annual meeting?

Any physician who is interested in learning more about the issues which will effect the future of medicine, who wants to keep current on technology by attending scientific seminars, and who just wants a chance to get out and talk with colleagues about issues of mutual interest.

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AIR FORCE

Nominees for SMS offices: 1992-1993

Pauline M. Jackson, MD
Nominated for president elect for 1992-1993.

Dr Jackson is currently serving as treasurer of the SMS. She has been a member of the SMS Board of Directors since 1979. She has served on the SMS Committee on Mental Health since 1981 and was chair from 1981 to 1985. She is a member of the SMS Physicians Alliance Commission. She has been on the Committee on Child Abuse and Neglect, the Committee on Women Physicians, the Committee on Alcoholism and Other Drug Abuse, served as chair of the Task Force on Competition and Regulation, and is a member of the Board of the Charitable Educational and Scientific Foundation of SMS. She chaired the Finance Committee of CESF from 1986 to 1990. Dr Jackson was a member of the SMS Strategic Planning Committee. She currently is on the Joint Committee on Interprofessional Relations, Mental Health Committee, and Managing Committee of Statewide Physicians Health Program.

Dr Jackson served as president of the La Crosse County Medical Society in 1984 and 1985, and served as secretary of the Wisconsin Psychiatric Association, and was its president from 1987 to 1989. She has served on the Board of Directors of the Gundersen Clinic and as chief of staff at Lutheran Hospital in La Crosse.

Dr Jackson graduated from Stanford University Medical School and served her internship at Charles T. Miller Hospital in St Paul. Board certified in psychiatry, she completed her residency at the Cleveland Psychiatric Institute.

Pauline M. Jackson, MD

William P. Crowley, Jr, MD
Nominated for treasurer for 1992-1993.

Dr Crowley had served on the SMS Board of Directors from 1976 to 1985. He had served on the SMS Committee on Economic Medicine and is an assistant treasurer of SMS, serving from 1985 to the present. Dr Crowley has served on the Board of Directors and as president of SMS Services, Inc, from 1980 to 1989. He graduated from the University of Wisconsin Medical School and served an internship at the Graduate Hospital of the University of Pennsylvania. His general internal medicine residency was served at the Mayo Clinic in Rochester.

William P. Crowley, Jr, MD

Kenneth I. Gold,MD
Nominated for vice speaker of the House of Delegates for 1992-1994

Dr Gold graduated from the State University of New York, Health Sciences Center in Brooklyn. He completed a residency in internal medicine at the University Hospital in Columbus, Ohio, and fellowship in psychiatry and medicine at Strong Memorial Hospital in Rochester, NY.

Dr Gold has been a member of the SMS Board of Directors from District 2 since 1985, and served on the Commission on Continuing Medical Education from 1982 to 1991, and as chair from 1988 to 1991. He is an editorial associate of the *Wisconsin Medical Journal* and a member of the Health Practices Advisory Committee and the Advisory Council for WIPRO. Dr Gold was president of the Rock County Medical Society 1986 to 1988, and served as

Continued on page 141

Kenneth I. Gold, MD

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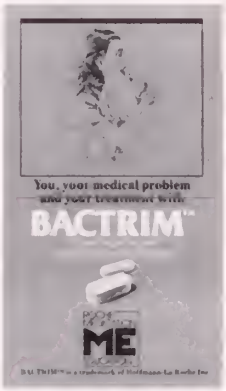

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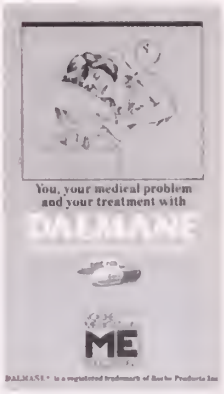

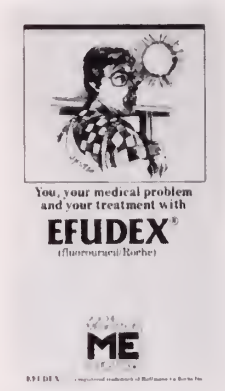

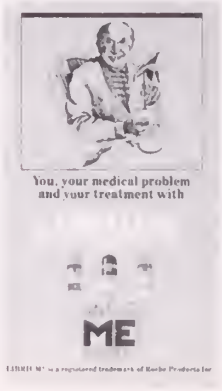

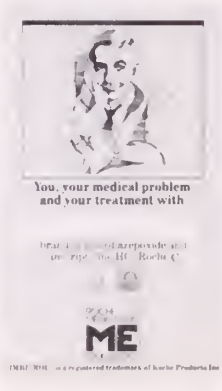

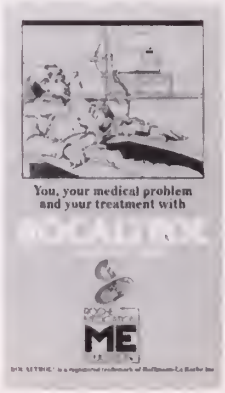

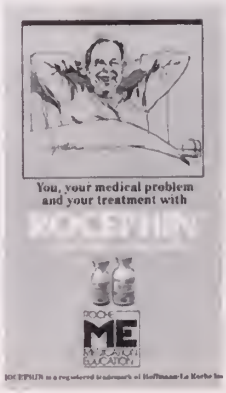

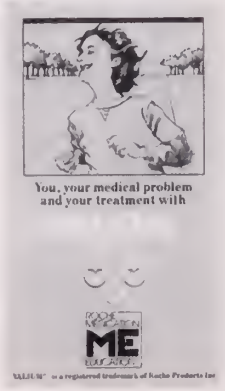

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president of the Beloit Memorial Hospital medical staff. He also is a member of the Wisconsin Society of Internal Medicine, having served as president in 1980-1981. He is a member of the American College of Physicians, Wisconsin Chapter, and has served as its secretary. Dr Gold has served as vice speaker since 1990. He currently is vice president of Medical Affairs at Beloit Memorial Hospital.

John P. Mullooly, MD

Robert F. Purtell, Jr, MD

John K. Scott, MD
Nominated for delegate to the AMA for 1993 and 1994.

Dr Scott has served as an SMS delegate to the AMA since 1979, and as alternate delegate from 1976-1978. He has been a member of the AMA Council Long Range Planning and Development since 1985 and is the current chair. Dr Scott served as president of the SMS, Dane County Medical Society, American Cancer Society, Wisconsin division, and the Wisconsin Chapter of the American College of Surgeons. He is a member of the American Academy of Ophthalmology and Otolaryngology, Society of Head and Neck Surgeons, and American Laryngological, Rhinological and Otological Society.

Certified by the American Board of Otolaryngology, Dr Scott served as president of the Wisconsin Otolaryngology Society. He is a clinical professor of surgery (ENT) at the University of Wisconsin Medical School, Madison.

Dr Scott graduated from Ohio State University College of Medicine, and completed his residency at University Hospitals, Columbus, Ohio.

John K. Scott, MD

John P. Mullooly, MD
Nominated for delegate to the AMA for 1993 and 1994.

Dr Mullooly has served as alternate delegate to the AMA since 1985 and delegate since 1991. He is a member of the SMS Committee on Medicine and Ethics and is currently an editorial associate for the *Wisconsin Medical Journal.* Dr Mullooly served as president of SMS in 1986-1987 and of the Medical Society of Milwaukee County in 1984. He received an SMS Meritorious Service Award in 1985. He served as president of both Milwaukee Academy of Medicine and Catholic Physicians Guild. He has been editor of *Linacre Quarterly* since 1969.

Dr Mullooly is a member of the Wisconsin Society of Internal Medicine, the Wisconsin Heart Association, and the American College of Physicians. He received the Addis Costello Internist of the Year Award from the WISM.

Dr Mullooly graduated from Marquette University School of Medicine and completed his residency at Milwaukee County General Hospital. He has been an assistant clinical professor of medicine at the Medical College of Wisconsin since 1966.

Robert F. Purtell, Jr, MD
Nominated for alternate delegate to the AMA for 1993 and 1994.

Dr Purtell is a member of the SMS Board of Directors. He had served on the SMS Physicians Alliance Commission for 12 years and served as chair for 4 years. Dr Purtell has been a member of the Nominating Committee since 1984 and is the current president elect of the Medical Society of Milwaukee County. Dr Purtell is a delegate to the American Academy of Family Physicians from the Wisconsin Academy of Family Physicians, a past president of the WAFP, and a past president of the Marquette Medical College of Wisconsin Medical Alumni Association. He is currently on the AAFP Commission on Public Health and Scientific Affairs. Dr Purtell is an assistant clinical professor at the Medical College of Wisconsin.

Dr Purtell graduated from Marquette University School of Medicine and served an internship at Misericordia Hospital. His residency was at St Joseph's Hospital in Milwaukee. He served as an alternate delegate to the AMA in 1991 and 1992.

Jerome W. Fons Jr, MD

Jerome W. Fons Jr, MD
Nominated for alternate delegate to the AMA for 1993 and 1994.

Dr Fons served as the SMS alternate delegate to the AMA since 1988. A member of the SMS since 1964, he served as a member of the SMS Board of Directors from 1981 to 1988 as well as a member of the SMS Physicians Alliance Commission and the Task Force on Medical Liability. He is currently a member of the SMS Committee on Medical Liability. Dr Fons served as president of the Medical Society of Milwaukee County in 1986. He is currently the president of Physicians Insurance Company of Wisconsin. In 1989, Dr Fons received the SMS Physician-Citizen of the Year Award.

Dr Fons graduated from the Marquette University School of Medicine and served his internship and residency at St Joseph's Hospital in Milwaukee. He was on the medical staffs of Trinity Memorial Hospital, Cudahy, and St Francis Hospital in Milwaukee.

SMS
Annual Meeting
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Patricia J. Stuff, MD
Nominated for delegate to AMA for 1993 and 1994.

Dr Stuff has been an AMA delegate since 1979, and an alternate delegate from 1977 to 1978. She chaired the AMA Ad Hoc Committee on Women Physicians in Organized Medicine, and served on AMA House of Delegates as reference committee member, chair, and chief teller. She has served a vice speaker and speaker of the SMS House of Delegates from 1973 to 1977. Dr Stuff has served as a member of the SMS Nominating Committee and of the House of Delegates reference committees. She was chair of the SMS Committee on Women Physicians. She is currently serving as chair of the AMA delegation and also is treasurer of the AMA Women's caucus. Dr Stuff is the medical director of the Shawano County Hospital and the Hartland of Shawano Nursing Home.

Dr Stuff served as adjunct professor at the University of Wisconsin, Oshkosh.

She is on the Board of Directors of Community Programs of Shawano County, and was the recipient of Woman of the Year Award by Shawano County Business and Professional Women's Association.

Dr Stuff graduated from Woman's Medical College of Pennsylvania and completed her residency at Sacred Heart Hospital in Yankton, SD.

Patricia J. Stuff, MD

Cyril M. "Kim" Hetsko, MD
Nominated for alternate delegate to the AMA for 1993 and 1994.

Dr Hetsko is currently serving as president of the SMS. He served as vice speaker of the SMS House of Delegates, and member of the Task Force on RBRVS, and is currently an alternate delegate to the AMA, and chair of the Task Force on AIDS. His past service includes the SMS Board of Directors, SMS Executive Committee, SMS Finance Committee (chair), Strategic Planning Committee, and Task Force on Physician Discipline and Review. In late 1991, Dr Hetsko was elected as a trustee of the American Society of Internal Medicine in Washington, DC.

Cyril M. "Kim" Hetsko, MD

Certified by the American Board of Internal Medicine, Dr Hetsko is a member of the Wisconsin Society of Internal Medicine, serving as the president in 1987-1988. He was a member of the Governing Council, was secretary-treasurer, served as chair of the Nominating Committee and also was the co-chair of the 1989 Scientific Meeting Program for that organization. Dr Hetsko has served as chair of the Department of Medicine at St Marys Hospital Medical Center (Madi-

Continued on page 144

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Continued from page 142
son), was a member of its Medical Staff Executive Committee, was a member of its Institutional Review Board and is a member of its Infection Control Committee. He received the Presidential Award from the Dane County Medical Society and an SMS Meritorious Service Award.

Dr Hetsko graduated from the University of Rochester School of Medicine and completed his internship and residency at University of Wisconsin Hospitals in Madison. He has been a member of the Dean Medical Center since 1975 and is a clinical associate professor of medicine at the University of Wisconsin, Madison. Dr Hetsko served as a major at the US Army Medical Research Institute of Infectious Diseases in the early 1970s.[15th]

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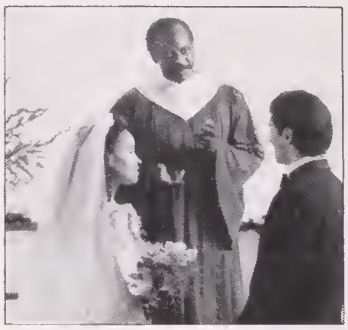

To make sure you get all the benefits you've earned, let Social Security know whenever you change your name. Not telling us could postpone your tax refund. You should also check the wages and taxes reported to us against the W-2s you received. It's easy. Just ask for a "PEBES" form by writing Dept. 36, Pueblo, Colorado 81009.

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Notice to members

Proposed amendments to the SMS constitution and bylaws

THIS NOTICE is given to SMS members, pursuant to Article XIII of the SMS constitution, of the following three proposed constitutional amendments introduced at the 1991 SMS annual meeting of the House of Delegates. These may be taken up as old business at the second session of the 1992 SMS annual meeting of the House of Delegates.

Proposed amendment A

Introduced by the House of Delegates Task Force on Board Representation

The articles and bylaws would need to be amended as follows:

Article VI Board of Directors

The Board of Directors hereinafter referred to as "Board," shall have full authority and power of the House of Delegates between sessions of the House. It shall consist of the directors, immediate past president, president, president-elect, speaker and vice speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Board, but without the right to vote. A majority of its voting members shall constitute a quorum.

Thirteen d~~D~~irectors shall be elected from ~~eight~~ nine geographic districts whose boundaries shall be determined by the House of Delegates. There shall be elected four directors from district one, two directors from district two, and one director from each remaining district. In addition, the House of Delegates shall elect three at-large directors. ~~there shall be elected director(s) from each district based on a formula using the number of members in each district as the numerator and the total membership of the Society as the denominator, rounded to the nearest whole number. This calculation shall be made every third year, and as nearly as possible, is to provide for no more than 31 district directors and shall be based on the year end membership totals. The number of directors established for each district shall be approved by the Board and shall be reported to the districts by the secretary before annual elections to the Board.~~ As nearly as possible, one-third of the members of the Board shall be elected each year.

Each director, except the at-large directors who shall be nominated and elected by the House of Delegates, shall be nominated and elected only by the elected delegates of the county medical society or societies from the district in which the director's principal place of practice is located. Such election shall be subject to the approval and confirmation of the House of Delegates.

The terms of the directors shall be for three years, except the initial terms of the directors shall be staggered, with four directors and one at-large director serving an initial term of one year, four directors and one at-large director serving an

initial term of two years, and five directors and one at-large director serving an initial term of three years. No individual shall be permitted to serve more than three consecutive three-year terms as director, and no more than a total of six terms of service as director shall be permitted.

Bylaws

Chapter III Annual election

Sec 3. The House of Delegates shall elect the president-elect, the treasurer, the speaker and vice speaker of the House of Delegates, the at-large directors, and the delegates and alternates to the American Medical Association.

Proposed amendment B

Introduced by the Special Reference Committee on Board Representation

The articles would need to be amended as follows:

Article VI Board of Directors

The Board of Directors hereinafter referred to as "Board," shall have full authority and power of the House of Delegates between sessions of the House. It shall consist of the directors, immediate past president, president, president-elect, speaker and vice speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Board, but without the right to vote. A majority of its voting members shall constitute a quorum.

Thirty d~~D~~irectors shall be elected from ~~eight~~ nine geographic districts, lettered A through I, whose boundaries shall be determined by the House of Delegates. There shall be elected nine directors from district A, two directors from district B, two directors from district C, four directors from district D, three directors from district E, three directors from district F, three directors from district G, two directors from district H, and two directors from district I. ~~one director from each district. In addition, there shall be elected director(s) from each district based on a formula using the number of members in each district as the numerator and the total membership of the Society as the denominator, rounded to the nearest whole number. This calculation shall be made every third year, and as nearly as possible, is to provide for no more than 31 district directors and shall be based on the year end membership totals. The number of directors established for each district shall be approved by the Board and shall be reported to the districts by the secretary before~~

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

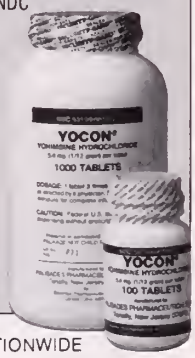
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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~~annual elections to the Board. As nearly as possible, O~~one-third of the members of the Board shall be elected each year.

Each director shall be nominated and elected only by the elected delegates of the county medical society or societies ~~from~~ within the district in which the director's principal place of practice is located. Such election shall be subject to the approval and confirmation of the House of Delegates.

The terms of the directors shall be for three years, except the initial terms of the directors shall be staggered, with ten directors serving an initial term of one year, ten directors serving an initial term of two years, and ten directors serving an initial term of three years. No individual shall ~~be permitted to~~ serve more than three consecutive three-year terms as director, and no more than a total of six terms of service as director shall be permitted.

Proposed amendment C

Introduced by Frank Urban, MD

To rescind the 1989 amendment of Article VI which capped the Board to no more than 31 elected district directors and reinstate the Article VI language then in effect prior to that amendment, the articles would need to be amended as follows:

Article VI Board of Directors

There shall be elected one director from each district~~.~~, except that in any district with 200 or more regular and special members, there shall be elected one additional director for each additional 200 members or majority fraction thereof. ~~In addition, there shall be elected director(s) from each district based on a formula using the number of members in each district as the numerator and the total membership of the Society as the demonimator, rounded to the nearest whole number. This calculation shall be made every third year, and, as nearly as possible, is to provide for no more than 31 district directors and shall be based on the year end totals. The number of directors established for each district shall be approved by the Board and shall be reported to the districts by the secretary before annual elections to the Board.~~[150th]

Vision, imagination, and leadership: William Shainline Middleton, MD, 1890-1975

"I have been given the privilege of preaching the only gospel I know, bedside medicine; and my greatest reward has been the emergence of the student's inquiring mind."
-William S. Middleton, MD

A YEAR BEFORE his death, as he received the Distinguished Teacher's Award from the American College of Physicians, William Shainline Middleton, MD, chose to reflect on his life–as a physician, a veteran of two world wars, and a much revered professor of medicine. He stated that the essential ingredients of education in any field included intelligent, receptive students; inspired, well-motivated teachers; and ready, open channels of communication. Aware or not, Dr Middleton was describing the primary reason for his immense success in and out of the classroom–from the students who remember their first class with him to the late President Kennedy, the lines of communication were always open to the guidance and inspiration of Dr Middleton.

Still a teenager, William Middleton was far from Madison in 1907-1908 when typhoid fever swept through the University of Wisconsin campus, but the epidemic would prove to be a guiding factor in his life. Thirty-four students were struck down by the fever; seven died. A minor diphtheria epidemic followed. In the wake of disease, the director of the state laboratory of hygiene urged development of a student health service on the Madison campus. UW administrators agreed, and hygiene director Mazyck Ravenel, MD, sought the aid of his friend from the University of Pennsylvania, Joseph Spragg Evans, MD, in launching the fledgling program.

Four years later, Dr Evans returned to the Pennsylvania hills looking for an associate. Following the advice of a friend, he sought out a young doctor, William Middleton, who had just completed an internship at Philadelphia General Hospital and was working at Babies Hospital in Wynnewood, just outside of Philadelphia.

In becoming a physician, Dr Middleton had achieved a lifelong dream. As boy of 3, William Middleton expressed his first desire to become a physician. In later years, his sister, Rena, recalled that her brother had only wavered from his objective once–at age 9, he considered running for US president.

Dr Middleton arrived in Madison in September 1912, the first of his family to travel beyond the Appalachian Mountains. His charge was to help run the new student health service and formulate a department of clinical medicine. Dr Middleton taught physical diagnosis–looking at, listening to, and touching the patient--along with clinical diagnosis at the bedside, which became and remained the physician's greatest love throughout his career.

William S. Middleton, MD

When Dr Middleton first arrived in Madison, a majority of the medical students were older than he was. Young and brash, he set out to devise an approach that would keep students alert and on their toes. There was a saying popular in the East about that time, "That takes the Brown Derby," and Dr Middleton took the expression and made it his own. "Well, that takes the Brown Derby," was his trademark response whenever a student answered a question incorrectly in class. The brown derby would soon become a hallmark medical school tradition. Each year, the junior class would present Dr

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Middleton with a brown derby that he, in turn, would dispatch to the first student to answer incorrectly that semester. The offending student would sign his name on the hat, then eagerly await the next errant answer so he could transfer the derby to a classmate.

The physician loved the beauty of the Madison area, particularly the lakes. May to September, he began each day with a 5 a.m. swim in Lake Mendota.

Dr Middleton left Madison in 1917 to serve in the US Army Medical Officers Corps, attached first to the British Expeditionary Forces and later to the American Expeditionary Forces. He served in the front lines and was involved in several gas attacks. Dr Middleton returned to civilian life and Madison's Student Infirmary in 1919.

For the next 15 years at Madison, Dr Middleton honed his teaching skills, becoming an associate professor, and then professor in 1933. While he taught superbly in the classroom, his preferred place still remained at the patient's bedside. He was hardly ever seen without his cherished stethoscope. In 1935, Dr Middleton became dean of the University of Wisconsin Medical School, and served in that capacity for 20 years, attending to patients in the morning and dean's duties in the afternoon. He published hundreds of clinical investigations and writings. At least 15 of the nearly 300 articles he wrote during his lifetime were on physical diagnosis.

With the onset of World War II, Dr Middleton requested active duty and returned to the US Army Medical Corps as a lieutenant colonel. In July 1942, Dr Middleton was named "chief consultant in medicine" in the Office of the Chief Surgeon, European Theater of Operations. Besides being responsible for the medical care of all the troops in Europe, his goal was to improve the quality of medical care by providing educational programs for medical officers. Dr Middleton participated actively in formal academic instruction at the Air Force Provisional Field Service School and the Army Medical Field Service School. He served until 1945, at which time he returned to his duel role as professor of medicine and dean.

Dr Middleton, reknowned as a teacher, retained his passion for patient care throughout his career.

Other demands were also being made of the physician beyond the borders of Madison. He served as expert and consultant to the Department of the Army both in the United States and in Europe. He had a period of active duty in 1948 on the General Staff (G-1) in the Pentagon. He served as chair of the Armed Forces Medical Advisory Committee relating to the medical reserve of the several armed forces. He was elected and served as president of the American College of Physicians, 1950-1951, and chaired the advisory board on medical specialties, coordinating the activities of the American certifying boards. He was also a member of the first American Board of Internal Medicine, which began certification 1936.

In 1955, Dr Middleton retired as dean, and accepted the position of chief medical director of the Veterans Administration. Five years later, the university named him both emeritus dean and emeritus professor of medicine. During his two terms as chief medical director, Dr Middleton created an advisory committee on aging; an advisory committee on research; educational programs and training in VA Hospitals; and plans for the relocation of medical schools using VA hospitals and personnel.

Expansion of the University of Wisconsin's Medical Library was one of Dr Middleton's chief goals. He initiated the idea of soliciting contributions from faculty, alumni and friends and turned over all honoraria he received to a library fund. Before he left for Washington, he had raised more than $70,000. The Medical

Alumni Association then took on the campaign with Dr Middleton authorizing use of his name in the fund-raising drive. More than $800,000 was pledged and the building, the first on the UW campus to be constructed primarily with private funds, was dedicated May 26, 1967. As Dr Middleton was still very much alive, university officials voted to waive the rule requiring buildings to be only named after the dead, and the library was officially christened the William S. Middleton Library.

Upon Dr Middleton's retirement from the Veterans Administration, President John F. Kennedy took the unusual action of summoning Dr Middleton to the White House for a personal expression of thanks. Kennedy said, among other things, "On your retirement from the federal service, I am impressed by the example your life provides of the completely selfless dedication of an individual to the needs of mankind, and for service to the veteran which provided vision, imagination and leadership that molded and energized the medical program of the Veterans' Administration."

The day after Dr Middleton returned to Madison, he was teaching on the wards of the VA Hospital.

In 1976, a year after Dr Middleton's death, President Gerald R. Ford signed Public Law 94-420 designating the Veterans Administration Hospital in Madison as the "William S. Middleton Memorial Veterans' Hospital." It was only the sixth time in US history a man had been so honored.

Much of the historical data found on Dr Middleton was obtained from a historical feature by Irvin M. Becker that appeared in the Spring 1991 issue of the *Wisconsin Medical Alumni Magazine Quarterly*. Photos courtesy of the Wisconsin State Historical Society.

A glimpse into our past

Richard D. Sautter, MD, medical editor

30 years ago

The cost of living has risen a bit. A Fox Valley hospital with 1,000 beds recruited physicians with "beginning salaries up to $18,672, depending on training and experience." The medical director could earn "$14,172 to $16,572, depending on qualifications." I would like to know what the house officers salaries were at the same hospital during that time.

Has the world changed, or have we? The *WMJ* offered free copies of publications on civil defense. "The Family Fallout Shelter" explained the need for shelters and how to live in them, and gave basic plans for building one. Three others, "First Aid," "Individual and Family Preparedness," and "Home Protection Exercises" related their topics to the family fallout shelter.

House calls as a matter of debate. The SMS president, Nels Hill, MD, devoted one of his "President's page" editorials in the *WMJ* to "the present day controversial subject of house calls." He concluded that "with due consideration of the value of the hospital and the physician' office in the practice of medicine, the house call still remains an irreplaceable adjunct to the care and treatment of the patient." All those who still make house calls, please raise your hands?

60 years ago

Defining "doctor." The Langlade County Medical Society passed a resolution to put the *Antigo Daily Journal* on notice that according to Wisconsin statutory law, "no person not possessing a license to practice Medicine and Surgery, Osteopathy or Osteopathy and Surgery ... shall use or assume the letters 'Doctor,' 'Dr,' 'Specialist,' 'Mr' 'DO' or any other title, letters or designation which represents or may tend to represent him as a Doctor in any branch of treating the sick." After the business meeting, "the smoker and an hour of social pleasure was enjoyed."

An epidemic strikes. "The ravages of the recent infantile paralysis epidemic" struck 71 Wisconsin counties. The epidemic was checked by the use of "convalescent serum" made from blood provided by individuals who had had infantile paralysis. The State Laboratory of Hygiene paid $25 for each pint of blood donated, plus traveling expenses to and from Madison. I remember the fears my parents had about infantile paralysis. One of the great things in American medicine is that one of our physicians discovered the vaccine and presented it to the world.

Flying is safer the driving–or riding. The *WMJ* reported that "horses and horse-drawn vehicles caused 16 deaths in Wisconsin during the first eight months of 1931, while only six persons lost their lives in aeroplane accidents during the period." You have to wonder what the ratio was of horses to "aeroplanes" in the early '30s of Wisconsin.

90 years ago

No need to call out the police. The SMS president, W.H. Neilson, MD, thanked the president of the Milwaukee Common

Continued on next page

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Council for his welcome of the SMS annual meeting to his city, then added: "I desire to assure you, however, that in accepting this welcome, you need give yourself no uneasiness that it will be abused; it will not be necessary to increase the police force nor in any other way prepare for emergencies. Doctors are proverbially sober folk, and while a few of an inquiring turn of mind may desire to investigate those mysterious decoctions known only to the Milwaukee dispensers of liquid refreshment, and while a few, or perhaps a good many, may desire to quench their thirst in that liquid which has made Milwaukee famous, yet it will all be done in decency and order."

Signs of sanity. A graduate of the University of Michigan who also graduated from a "homeopathic school" later renounced homeopathy and declared himself a "regular physician," applied for membership to the SMS. The application caused a great debate at the SMS annual meeting, during which Dr W.A. Gordon pronounced that: "When a homeopath manifests contrition and repentance and signs of sanity, I think he ought to be encouraged. This gentleman has seen a great light.... He is no longer a dogmatist or a bigot, but has opened his mind to the truth. All such men should be encouraged for they are courageous."

Family planning under fire. Support was expressed at the SMS annual meeting for a resolution passed by the Kansas City Academy of Medicine and the Wisconsin State Eclectic Medical Society that called on the federal government to censor newspapers that carried "personal medical advertisements" for "nostrums and means intended to prevent or cut short pregnancy." The resolution proclaimed that the "American race is rapidly decreasing in its birth rate, thereby threatening ultimate and complete decadence of the race..." The birthrate has been a problem in this country for a very long time. It would be interesting to know how these same people would have reacted to handing out condoms in junior high schools.[15,16]

Physician briefs

Gregory L. Darrow, MD,* has been appointed director of the Southern Wisconsin Family Practice Residency program affiliated with Mercy Hospital. The 3-year program offers comprehensive training to residents in family medicine. Dr Darrow, certified by the American Board of Family Practice, received his medical degree from the Indiana University School of Medicine. He was in private practice in Terre Haute and Janesville, and was affiliated with the Janesville Medical Center. His practice is now located at Mercy Center for Family Medicine.

Sheryl A. Spitzer, MD,* an internal medicine specialist, has joined Dean Medical Center in Madison. She earned her medical degree at Washington University in St. Louis, Mo, and completed her residency at Gundersen Medical Foundation at Lutheran Hospital in La Crosse. She comes to Madison from the Midelfort Clinic in Eau Claire.

Sridhar V. Vasudevan, MD, * has been promoted to clinical professor of physical medicine and rehabilitation at the Medical College of Wisconsin in Milwaukee. Dr Vasudevan is chair of the Department of Physical Medicine and Rehabilitation at St Joseph's Hospital in Milwaukee. He is immediate past president of the American Academy of Pain Medicine and the Wisconsin Society of Physical Medicine and Rehabilitation.

Nolan Hetz, MD,* has recently been accepted as a fellow in the American College of Obstetrics and Gynecology. Dr Hetz has offices in Manitowoc and Two Rivers.

John Devine, MD, has joined the River Valley Medical Clinic staff. A family physician, Dr Devine earned his medical degree from the New England College of Osteopathic Medicine in Biddeford, Me, in 1983, then entered a family practice internship and residency program in Milwaukee. Dr Devine practiced medicine for the US Public Health Service in Montana and South Dakota. After 3 years, he returned to Maine and continued practicing family medicine.

Kristine M. Klewin, MD, is taking over the ophthalmology practice of **James E. Ney, MD,** in Oconomowoc. Dr Klewin earned her medical degree from the University of Wisconsin and completed a 1-year fellowship, specializing in the treatment of glaucoma.

Susan R. Davidson, MD,* has joined Dean Medical Center as an obstetrics/maternal-fetal medicine specialist. She will direct high-risk maternity services at Dean Medical Center and St Marys Hospital Medical Center. Dr Davidson was affiliated with the UW Department of Obstetrics and Gynecology since 1986. She completed a fellowship in 1988.

Donald Fisher, MD, has been named the Physician of the Year for 1991 by CPC Greenbriar Hospital. Dr Fisher has been the medical director of the hospital since 1990. He currently oversees clinical programs at the hospital and is a former chief of staff. Dr Fisher graduated from the University of Wisconsin School of Medicine in 1977.

Caesar R. Gonzaga, MD,* a general surgeon, has joined the staff of the Marshfield Clinic Chippewa Center. Dr Gonzaga earned his medical degree from the University of Santo Tomas, Philippines. He completed his surgical residency at American Hospital and St. Joseph's Hospital in Chicago and served a surgical preceptorship at St Joseph and Augustana hospitals in Chicago. He began his practice in the Chippewa Falls area in 1970.

Mary Horowitz, MD, associate professor of medicine at the Medical College of Wisconsin, Wauwatosa, has been named new scientific director of the International Bone Marrow Transplant Registry based at the college. She succeeds **Mortimer Bortin, MD,** research professor, who stepped down last August after 20 years in that post.

Daniel J. DeBehnke, MD, has been appointed assistant professor of emergency medicine at the Medical College of Wisconsin. Dr DeBehnke practices in the trauma center of the Milwaukee County Medical Complex. An Oshkosh native, he completed a residency in emergency medicine at Wright State University in Dayton, Ohio, where he won numerous achievement awards. He is a 1988 graduate of the University of Wisconsin School of Medicine.

Betty Hagle, DO, has joined the staff of the Ovitz-Castaldo Memorial Clinic in Laona. Dr Hagle earned her degree from the Chicago College of Osteopathic Medicine. She has been in private practice in New Berlin for 24 years.

David L. Hahn, MD,* has been named medical director of the Dean Foundation for Health, Research and Education. Dr Hahn is in family practice at Dean Medical Center's Arcand Park Clinic in Madison. He is also the author of a recent foundation-funded study on asthma and its possible link to a bacterial strain.

Jean R. Goodman, MD,* is a new physician at Marshfield Clinic, having completed a fellowship in maternal-fetal medicine and a residency in obstetric and gynecology at the University of Miami Jackson Memorial Medical Center. She earned her medical degree at Georgetown University School of Medicine in Washington, DC.

Larry K. Heath, MD,* recently joined the Marshfield Clinic staff. He completed a fellowship in infectious diseases and immunology and a residency in internal medicine at the University of California-Davis. He also served a residency at San Joaquin General Hospital in Stockton, Calif. He earned his medical degree at UCSF Medical Center in San Francisco.

Continued on next page

PHYSICIANS WANTED

The Air National Guard doesn't take just any physician who wants to be a member. We look for people who have only the highest standards themselves when it comes to their profession. Our medical unit is made of people who are dedicated to their medical professions, and who enjoy dedicating time to serve their country. All it takes is two days a month and fifteen days a year to be a member. You'll be eligible for more tangible benefits including a great retirement plan, low-cost insurance, educational advantages, as well as a monthly paycheck. If you qualify, you can even take to the sky as a Flight Surgeon, through a specialized training program. And, when you join the Air Guard you will automatically be comissioned as an officer. It doesn't matter whether you're on the ground or 30,000 feet in the air, the Air National Guard will put your skills to work for America, part-time.

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AIR NATIONAL GUARD
Americans At Their Best

Continued from preceding page

Joseph P. O'Grady, Jr, MD,* of Waukesha, has been appointed an assistant professor in the departments of psychiatry and mental health sciences and pediatrics at the Medical College of Wisconsin. He practices at several Milwaukee hospitals, all MCW teaching affiliates. Dr O'Grady serves as co-director of the Pediatric Psychopharmacology Clinic and co-directs the Consultation/Liaison Service at Children's Hospital.

Richard J. Gauthier, MD,* of Ripon, is the new chief of staff of Ripon Memorial Hospital. Dr Gauthier is in practice with Silver Creek Memorial Associates of Ripon and Princeton.

Gary L. Cohen, MD,* has joined the staff of Janesville Medical Center. The neurologist received his medical degree and completed his residency in neurology at George Washington University School of Medicine in Washington, DC.

James J. Tydrich, MD,* joined the staff of Riverview Clinic in Janesville in late January. Dr Tydrich, a board-certified specialist in family practice, relocated from Richland Center, where he practiced for 24 years. He obtained his medical degree from the University of Wisconsin in 1962.

IMGs propose changes to section constitution and bylaws

The SMS International Foreign Medical Graduate Section is proposing amendments to its constitution and bylaws. The amended constitution and bylaws that follow will be voted on by the section at its annual meeting scheduled for Friday, March 27, 1992. Proposed additions will be underscored, while deletions are indicated by strike throughs.

~~Foreign~~ International Medical Graduate Section constitution

Article I - Name and Title of the Section

The name and title of this organization shall be the ~~Foreign~~ International Medical Graduate Section of the State Medical Society of Wisconsin.

Article II - Purposes of the Society

The purposes of this Section are to provide a focal point for non-U.S. medical graduates to address their concerns in the State Medical Society, to increase membership and active participation of non-U.S. medical graduates in the State Medical Society, to monitor the requirements and procedures involved in granting of license to practice medicine in Wisconsin for graduates of non-U.S. medical schools, and to initiate and follow through necessary legislation to ensure equitable requirements on par with those of U.S. medical graduates. The Section shall also monitor reciprocity requirements of medical licensure in other states and advise members accordingly, monitor, help and advise non-U.S. medical graduates in problems associated with hospital appointments and privileges, and to monitor acceptance of medical graduates in residency programs in Wisconsin.

Article III - Eligibility

Every licensed physician residing and practicing in Wisconsin, who is a graduate of a non-U.S. medical school, and who is a member in good standing of the State Medical Society of Wisconsin, shall be considered a member of the Section.

Article IV - Meetings

Regular meetings shall be held at the time and place determined by the Bylaws of the Section.

Special meetings may be called by the ~~Chairman~~ Chair and shall be called by a written request of five members. A call for a special meeting shall state the object of the meeting, at which no business except that stated in the call shall be transacted.

Forty-percent of the Executive Committee membership shall constitute a quorum of the Executive Committee. The actual number of members present shall constitute a quorum for purposes of general membership business meetings, including the annual meeting.

Article V - Officers and Delegates

The officers of this Section shall consist of a ~~Chairman~~ Chair, ~~Chairman elect~~ Vice Chair, Secretary/Treasurer. These officers shall be elected annually. A delegate and alternate delegate to the State Medical Society shall be elected in the

manner and for terms prescribed in the State Medical Society Bylaws.

Article VI - Executive Committee

The Executive Committee shall consist of the Section officers, the delegate and alternate delegate and elected directors from ~~nine~~ eight geographic districts ~~whose boundaries shall be determined by the Executive Committee~~. There shall be one director from each district and the district will have the same boundaries as those used by the State Medical Society of Wisconsin Board of Directors.

~~There shall be elected one director from each district for every 500 State Medical Society members or majority fraction thereof, except that every district shall be entitled to a minimum of one director and no district shall have more than four directors. This calculation shall be made every year~~. Terms for the directors shall be for one year. No individual shall be permitted to serve more than three consecutive one-year terms as director. ~~Each director shall be nominated and elected at the annual meeting to serve as director from the district in which their principal place of practice is located~~. Each district shall elect one director at the annual meeting of the section to be held in March or April of each year.

The Executive Committee may, by interim appointment, fill any vacancy which may occur during the interval between annual meetings of the section. The appointee shall serve until a successor has been elected and qualified.

Article VII - Charter

The Section shall apply to the Board of Directors of the State Medical Society for approval of this Constitution and Bylaws and all amendments. The Section charter shall be kept by the Secretary/Treasurer.

Article VIII - Amendments

The Section may amend any article of this Constitution by a two-thirds (2/3) vote of the members present at any regular meeting provided that the amendment or amendments are not in conflict with the laws and regulations of the State Medical Society and that the amendment had been read in open session at a previous regular meeting and had been sent by mail to each member at least ten (10) days prior to the

Continued on next page

County society news

Dane. In January, nine physicians were accepted to membership in the society: Susan J. Carson, MD; Bartholomew D. Hobson, MD; James S. Gaffney, MD; Frederic A. Melius, MD; Mark Olsky, MD; Nabeel Jabri, MD; David B. Moore, MD; Daniel J. Sutton, MD; and Elizabeth A. Johnson, MD.

Rock. David G. Benzer, DO, was the guest speaker at the December meeting of the society. Dr Benzer spoke on stress and other causes of physician impairment. Elected as officers of the society for 2 years are David Murdy, MD, president, Kathleen Wick, MD, vice president, and Mark Lanser, MD, secretary-treasurer. Delegates appointed to SMS are Kathleen Wick, MD; Jeffrey Thomas, MD; Jordan Frank, MD; Paul Durkee, MD, and Larry Ojeda, MD. Alternate delegates appointed are Diana Wright, MD; R. Ken Bowers, MD; Rodrigo Merino, MD; Leland From, MD; and David Murdy, MD. Accepted to membership in the society were Gary Beehler, MD, and Amelia Rojas, MD.

Winnebago. Twenty-two members were present at the January meeting of the society. A discussion on cardiac surgery was led by Mohan Peter, MD. Veronica Solis-Rohr, MD, was accepted to membership in the society. A general discussion on the RBRVS and its implications took place.[150th]

SIXTH ANNUAL

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July 27-31, 1992

Session I Harry Levinson, Ph.D. — Organizational Diagnosis
Session II Russell Barkley, Ph.D. — Attention Deficit Disorders

August 3-7, 1992

Session III Albert Ellis, Ph.D. — Rational Emotive Therapy
Session IV Diana Kirschner, Ph.D. & Sam Kirschner, Ph.D. — Treating Survivors of Incest and Abuse
Session V James Jefferson, M.D. — Psychopharmacology Update

August 10-14, 1992

Session VI Jerrold Post, M.D. — Political Psychiatry
Session VII Stephen Rao, Ph.D. Thomas Hammeke, Ph.D. & Marielen Fischer, Ph.D. — Neuropsychological Testing

For more information:
Carlyle H. Chan, M.D., Summer Institute Director, Psychiatry Dept
Medical College of Wisconsin, 8701 Watertown Plank Road,
Milwaukee, Wisconsin 53226 (414) 257-5995.

Continued from preceding page
meeting at which final action is to be taken.

Article IX - Approval of the State Medical Society
The Constitution and Bylaws of this Section shall not be inconsistent with those of the State Medical Society or its regulations, and shall, together with amendments thereto, be subject to the approval of the Board of Directors of the State Medical Society.

~~Foreign~~ International Medical Graduate Section bylaws

Chapter I - Membership

Section 1. ~~Every legally licensed physician who is a member in good standing of the State Medical Society of Wisconsin, shall be considered a member of the Section~~. Every member as defined by Article III of the Constitution shall be considered a member of the Section. Eligibility for membership in the Section is contingent upon membership in the State Medical Society.

Section 2. All members shall be equally privileged to attend all meetings and take part in all proceedings and shall be eligible to hold any office or honor within the Section so long as they conform to this Constitution and Bylaws.

Chapter II - Powers and Duties

Section 1. The Section shall hold an annual meeting in March or April of every year, and meet at least one other time during the year. The annual meeting shall be held in Madison, at the offices of the State Medical Society, if possible.

Chapter III - Officers

Section 1. Section officers shall be elected each year at the annual meeting. Nominations shall be made either by a nominating committee or from the floor. A nominating committee may be appointed by the ~~Chairman~~ Chair. The vote of a majority of the members present shall be necessary for an election.

Section 2. The ~~Chairman~~ Chair shall preside at Section meetings and perform other duties as custom and parliamentary usage might require.

Section 3. The ~~Chairman-elect~~ Vice Chair shall assist the ~~Chairman~~ Chair in the performance of his or her duties, shall preside in the ~~Chairman's~~ Chair's absence, and shall succeed to the chair upon the ~~Chairman's~~ Chair's death, resignation, or inability to perform his or her duties as ~~chairman~~ chair.

Section 4. The Secretary/Treasurer shall record the minutes of the meetings and receive and care for all records and papers belonging to the Section including its Charter. The Secretary/Treasurer shall notify each Section member as to the time and place of each meeting, and whenever possible, give the program for the meeting.

Section 5. There shall be elected district-based directors to serve on the Executive Committee. ~~District boundaries shall be drawn to reflect geographic concerns, referral and practice patterns and the distribution of non U.S. medical school graduate physicians in Wisconsin~~. District boundaries shall be determined as stated in Article VI of the constitution.

Chapter IV - Committees

Section 1. There shall be special committees as may be necessary. A list of existing and proposed committees shall be published prior to the annual meeting and sent to each member in good standing. Each member shall return to the ~~chairman~~ Chair a list of committees on which he or she wishes to serve.

Section 2. The Executive Committee shall consist of the Section ~~Chairman, Chairman elect~~, Chair, Vice Chair, the Secretary/Treasurer, Delegates and district-based directors. The ~~Chairman~~ Chair shall have the right to appoint the ~~chairman~~ Chair of each Section committee and the Executive Committee shall have the right to choose members of each committee, with input from the committee ~~chairman~~ chair.

Section 3. Forty-percent of the Executive Committee membership shall constitute a quorum of the Executive Committee. The actual number of members present shall constitute a quorum for purposes of general membership business meetings, including the annual meeting.

Chapter V - Rules of Order

The current edition of Sturgis Rules of Order of Parliamentary Procedure governs this organization in all parliamentary situations not provided for by charter, constitution, bylaws or adopted rules.

Chapter VII - Amendments

These Bylaws may be amended at any regular meeting by a two-thirds (2/3) vote of the members present and voting, provided that the amendments have been read in open session at the last regularly scheduled meeting and have been sent to each member by the Secretary/Treasurer ten (10) days before the meeting at which final action is to be taken.[150th]

SMS members delve into the health care reform debates

Busy Wisconsin physicians took time out recently to share their views on health care reform, proposing diverse solutions and providing SMS leaders with new insights on front-line concerns.

About 70 physicians participated in the SMS-sponsored physician town hall meetings, held in Milwaukee and Wausau. The physicians–representing diverse specialities as well as educational and scientific backgrounds–suggested ways for improving the current health care system. Operation Reform, the SMS's 12-point plan, and the AMA-developed Health Access America proposal were among the many plans detailed and considered.

Although much of the discussion centered around the multitude of health care proposals now under consideration at the nation's capital and in the Wisconsin statehouse, many physicians also offered practical suggestions for addressing factors contributing to high health care costs. A few doctors who could not attend submitted written comments to Dr Hetsko, who shared them with those in attendance.

'Americans tend to want the best, and they want it now. . .'

SMS President Cyril M. "Kim" Hetsko, MD, moderated the physician forums and urged all SMS members present to take a turn at the microphone, noting, "It is important that all physicians be a vital part of the process of change which is occurring in the health care system.

"We certainly most all do agree that we have serious problems in this country in terms of the rising cost of health care, and that we have serious problems in this country in terms of access to health care and, likewise, uninsured or underinsurerd parts of the population," Dr Hetsko said.

The SMS president stressed that an underlying problem with the current system is that patients want quality care, but don't want to pay for it.

SMS President Cyril M. "Kim" Hetsko, MD, moderates a discussion on health care reform.

"Americans tend to want the best and they want it now and they would like to have somebody else pay for it. And that is a basic problem we are going to have in dealing with any further evolution of our current health care system into the future. Unfortunately for those of us who would like to live in the past, the past will not continue on into the future, and I think we all have to recognize that fact," Dr Hetsko said.

The grassroots meetings drew valuable suggestions from SMS members–ideas, Dr Hetsko said, the SMS leadership will use in further developing positions on state and federal legislation. Many physicians spoke of the need to increase the voice physicians have in the development of health care reform. Doctors called for increased efforts to educate the public on actual realities of factors contributing to health care costs, eg, to let the public know that physicians fees account for only 4 percent of the exponentially ex-

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SMS Secretary-General Manager Thomas Adams, CAE, (l) discusses the issues with Maxwell Weingarten, MD, (c) and Raymond Zastrow, MD (r).

Kevin Jessen, MD

Janet Chene, MD

Robert Jaeger, MD

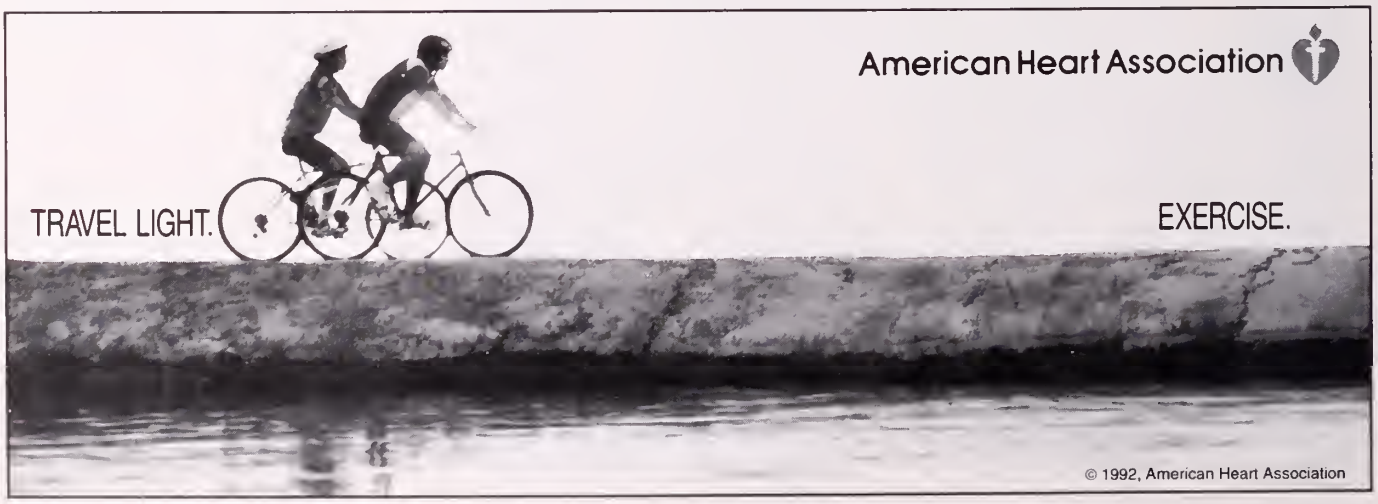
Continued from preceding page
panding Medicaid budget.

In addition, SMS members offered a wide gamut of suggestions. Some examples are:

- increasing the voice physicians have in the development of health care reform;
- increased sharing of expensive high-tech equipment between facilities;
- greater development and use of practice parameters;
- increasing federal income tax to permit expansion of Medicare;
- eliminating Medicare and Medicaid to return to private sector care;
- reducing medical malpractice insurance rates; and
- reallocating financial resources so more emphasis can be placed on preventative care and fewer resources are used for terminally ill patients.

Near the conclusion of each town meeting, physicians were informally polled on reactions to each of the questions posed in the SMS health care reform brochure.

Health reform discussions will continue in April at the 1992 SMS annual meeting in Milwaukee. Informational packets on health care reform proposals will be available at a physician town hall meeting, scheduled for Thursday, April 23, at 12:30 pm. Watch *Medigram* for more details and room arrangements.



Door County, Wisconsin. BC/BE internist. Modern, 89-bed community hospital with new outpatient services addition. Competitive guaranteed salary. Incentive package. Malpractice insurance. Attractive benefits. Exceptional four seasons recreation along Lake Michigan shores. Proximity to Milwaukee/Chicago. Top-rated schools. Quality community life. Send CV to Priscilla Khoury, Physician Recruitment Coordinator, 330 South 16th Place, Sturgeon Bay, WI 54235. 3-5/92

Milwaukee area. A rapidly expanding 60-physician multi-specialty clinic, seeks BC/BE physicians in the following specialties: internal medicine, family practice, orthopedic surgery, ob/gyn, urology, dermatology, and psychiatry. Competitive salary, excellent fringe benefits. Address inquiries and CV to: Administrator, PO Box 427, Menomonee Falls, WI 53052-0427. 3-5/92

Ideal internal medicine practice. Excellent opportunity for BC/BE internist to establish a prosperous practice. Progressive 107-bed community hospital with a medical staff of 45 physicians and a service area population of over 45,000. Vibrant northern Michigan community with all summer and winter recreational activities. Salary guarantee of $110,000 with excellent benefits. Send CV or contact: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Ave, Iron Mountain, Mich 49801; ph 800-323-8856. 3/92

Medical Director. Great Lakes! Direct your attention this way! New position with prestigious 40-member multi-specialty group of top income earners. Full-time, non-clinical opportunity. Physician advocate. Liaison to all parties. MD candidates should have experience and/or related graduate education. Highly competitive compensation package. A good attitude about medicine and a sense of humor preferred. Modern clinic located in mid-sized community on Lake Michigan between Milwaukee and Chicago. Rebecca Turley, Vice President, Fox Hill Associates, 250 Regency Court, Milwaukee, Wisconsin. Ph 1-800-338-7107; Fax 1-414-785-0895. 3-4/92

Door County, Wisconsin. Emergency medicine. BC/BE family practice, internal medicine, pediatrics, or emergency medicine. General emergency medicine experience required. ACLS/ATLS required. PALS preferred. Full-time position with 8-10 24-hour shifts monthly with flexibility. Competitive salary and benefits package. Modern 89-bed hospital with a new emergency department and outpatient services addition. Approximately 10,000 visits per year. Exceptional four seasons recreation along Lake Michigan shores. Proximity to Milwaukee/Chicago. Top rated schools. Quality community life. Send CV to Priscilla Khoury, Physician Recruitment Coordinator, 330 South 16th Place, Sturgeon Bay, WI 54235. 3-5/92

Family practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or set up his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr Paul Hayes' office 906-563-9255 or Dr william Gladstone's home 906-563-8743. Anderson Memorial Hospital, Main Street, Norway, Michigan 49870; ph 906-563-9243. 3/92

Family practice. Minneapolis. BC/BE family practice physicians needed to join the Family Practice Department of a 350-physician multi-specialty clinic in desirable Twin Cities area. Main center and branch office practices available. Salary and benefits are highly competitive. Send CV and letters of inquire to Peter Garske, MD, Park Nicollet Medical Center, 5000 West 39th St, Minneapolis, MN 55416. 3/92

Minneapolis/St Paul, Minnesota. Opportunities available for BE/BC internists to join a large, established multi-specialty group practice in the metro Twin Cities area. Excellent compensation and benefits package. Contact: Nancy Borgstrom, Aspen Medical Group, 1020 Bandana Boulevard West, St Paul, MN 55108; ph 612-641-7170. EOE.3/92

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Physicians Exchange

Continued

Family practice. Seven doctor multi-specialty clinic in central Wisconsin needs another family practitioner. Outstanding financial package and benefits. Contact Peter McNally or Sean Alwin, MD, Medford Clinic, 101 N. Gibson, Medford, WI 54451; ph 715-748-2121. p2-3/92

Minnesota. Private practice opportunities in family medicine. Join established clinics with first year guarantees, benefits, and quality management. **Arlington, Eden Prairie, Hopkins, Montgomery, Monticello, Mound, Morris, Wayzata & Grantsburg, Wisconsin.** Contact: Jerry Hess, LifeSpan Hospitals (16501) 800 East 28th St, Minneapolis, MN 55407; 800-248-4921 or 612-863-4193. 2-4/92

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Family practice physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD,MBA, PO box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 1-3/92

Wisconsin. Fourth BC/BE obstetrician/gynecologist needed to join stable, progressive, primary-care based HMO/group practice in University town of 60,000 near Minneapolis/St Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact Stuart R. Lancer, MD, MBA, Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702; 715-836-8552. 1-3/92

Internal medicine physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD, MBA, PO Box 3217, Eau Claire, WI 54702; ph 715-836-8552. 1-3/92

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The Wausau Medical Center is seeking board certified/eligible individuals in the following specialties: dermatology, family medicine, gastroenterology, hematology/oncology, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year-round as well. Write or call collect D. K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401; ph 715-847-3254. c1tfn/91

Family practice Wisconsin. Physician needed for partnership in broad based primary care practice in exceptional south central community. Shared call, fully-equipped and staffed office, very competitive guaranteed salary and comprehensive benefit package. For information on this and other opportunities in the upper Midwest, contact and send CV to Mary Jo Cordes, President, MDsearch, PO Box 21507, St Paul, MN 55121 or call 612-454-7291. FAX 612-454-7277. 12/91;1-3/92

Urgent care. Busy department in 60 member multi-specialty clinic to add urgent care physician immediately. Excellent salary and benefits. Beautiful southern Wisconsin. Send CV to Dr Stan Gruhn, Riverview Clinic, 580 N. Washington St, Janesville, WI 53545. 12/91;1-5/92

Family practitioner to join a progressive 13-physician group practice. Rural college town 30 miles from St. Paul, Minnesota, new clinic and constructing new hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. c9tfn/91

Seeking BC/BE general internist to work in established internists office in West Allis. Flexible hours, possible long term affiliation. Hospital and office practice. Guaranteed compensation plus incentive option. Please contact Barton-Collins Ltd, 9401 West Beloit Rd, Suite 312, Milwaukee, WI 53227; ph 414-541-6099. 3-4/92

Physicians Exchange

Continued

Internist to join two internists in active practice in scenic Upper Michigan. Medical school affiliation. Contact North Shore Internal Medicine, 2420 First Ave South, Escanaba, MI 49829; ph 906-786-1563. p11tfn/91

Internist to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, new clinic and constructing new hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. c9tfn/91

Madison, Wisconsin. Positions available: family practice & urgent care (full or part-time). Excellent salary, benefits, lifestyle. Contact Dr John Hansen, Medical Director, Group Health Cooperative, One South Park St, Madison, WI 53715; ph 608-251-4156. GHC is an equal opportunity/affirmative action employer. c5tfn/91

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Medical Meetings-Continuing Medical Education

April 20-11, 1992: Eleventh Annual OB/GYN Update: Electrosurgical Advances in Gynecology in Milwaukee. Contact: St. Francis Hospital, Educational Services at 414-647-5009. g2/92

April 22-25, 1992: Annual Meeting of State Medical Society of Wisconsin in Milwaukee. Info: 608-257-6781 or toll-free 1-800-362-9080. g2-3/92

May 29-30, 1992:1st Annual Clinical Neurology and Behavioral Sciences Symposium: Focus on Geriatrics, at Landmark Inn Resort, Egg Harbor. Info: Nadine Punke, Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449; ph 1-800-782-8581, ext 5207. 3-5/92

May 30, 1992: Cytokines and Transplantation, 3rd annual Rush symposium on transplantation, at Rush-Presbyterian-St Luke's Medical Center, Chicago, Ill. Fee: $150. To register, call 312-942-6242. 3-5/92

August 5-9, 1992: 43rd Annual Meeting International Doctors in AA (IDAA) in Grant Rapids, Michigan. Registration information: Connie Hyde, 3311 Brookhill Circle, Lexington, KY 40502; ph 606-233-0000; 606-277-9379; 606-253-0864 (FAX). 3-7/92

October 15-18, 1992: 44th Annual AAFP Scientific Assembly in San Diego. Info: AAFP, 8880 Ward Pkwy, Kansas City, MO 64114; ph 816-333-9700; 816-822-0580 (FAX). g3-9/92

November 8-12, 1992: Ninety-Sixth Annual Meeting of the American Academy of Ophthalmology at Dallas Center. Contact: The American Academy of Ophthalmology, Meetings Dept, PO Box 7424, San Francisco, CA 94120-7424; ph 415-561-8500. g3-9/92

Oshkosh, Wisconsin. Single specialty groups are recruiting in pediatrics, OB/GYN, pathology, cardiology, and orthopedic surgery. Oshkosh is an attractive community of 55,000 people, located on the shores of Lake Winnebago and in the heart of Wisconsin's beautiful Fox River Valley. Competitive financial packages. Contact Christopher Kashnig, Physician Recruiter, Mercy Medical Center, 631 Hazel St, Oshkosh, WI 54902, or call 800-242-5650, x2430 or 414-236-2430. c3/92

Beloit Clinic, SC, a 47-physician multi-specialty group is seeking a general surgeon, neurologist, OB/GYN, orthopaedic surgeon, physiatrist, plastic surgeon, rheumatologist, and urologist. Our clinic is located adjacent to a modern, progressive 180-bed community hospital. Guaranteed salary with incentive and excellent benefit package. Send CV to James Ruethling, Administrator, 1905 Huebbe Parkway, Beloit, WI 53511, or call 608-364-2200. 3-8/92

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Medical Meetings-Continuing Medical Education

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December 6-9, 1992: Interim House of Delegates, Nashville.

June 13-17, 1993: Annual AMA House of Delegates, Chicago.

December 5-8, 1993: Interim House of Delegates, New Orleans.

June 12-16, 1994: Annual AMA House of Delegates, Chicago.

December 4-7, 1994: Interim House of Delegates, Honolulu.

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Air Force Medicine 137
Air National Guard 151
Columbia Hospital 153
Door County Summer Institute
Eli Lilly & Company 122, 123
Axid®
General Internal Medicine 117
Medical College of Wisconsin
Mead Inn 121
Medical College of Wisconsin 119
Physician Referral Network
Medical Protective Company 143
Palisades Pharmaceuticals 146
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St Luke's Hospital 131
Searle Company, G.D. ..... BC
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Sister Bay Resort & Yacht Club 117
SMS Services ..... IBC
Wipfli Ullrich Bertelson CPAs 135
Wynn O. Jones & Associates 127, 128

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BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg,* copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association.*

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1992 - April 22-25: Milwaukee
1993 - April 15-17: La Crosse Convention Center, Radisson
1994 - April 14-16: Milwaukee

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

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Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk, therefore, nursing should be discontinued during verapamil use.

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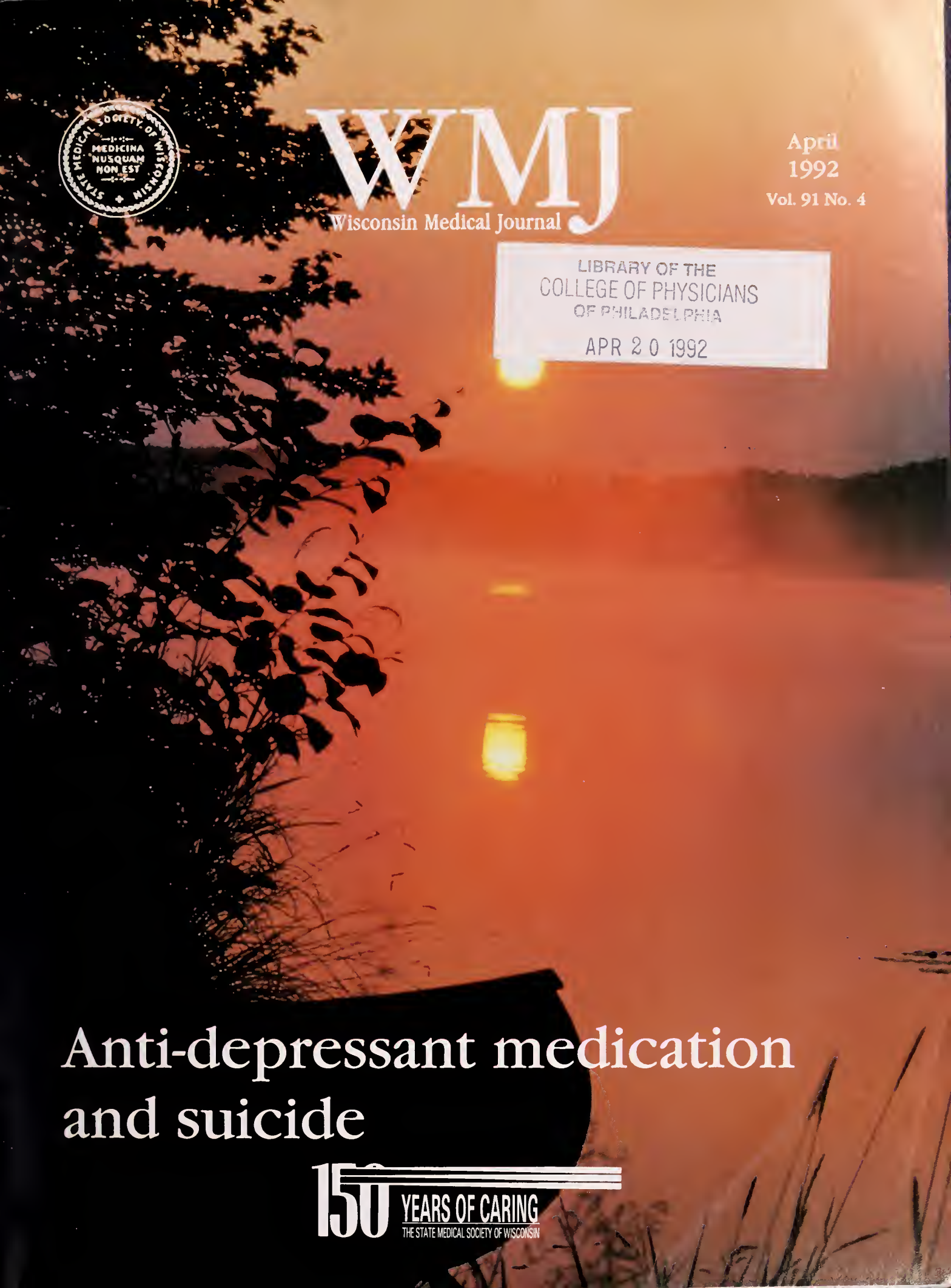
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Contents

April 1992 Vol. 91 No. 4

Opinions

163 *President's page*
Health care financing reform in Wisconsin: Prescription for the future
'Medicina nusquam non est' (medicine is universal): XI
by Cyril M. "Kim" Hetsko, MD, Madison
164 *Secretary's report*
For whom the bell tolls
by Thomas L. Adams, CAE, Madison
166 *Letters*
Cholecysto-sternal fistula
by Victor S. Falk, MD, Edgerton

Scientific

169 Antidepressant medication and suicide
by John H. Greist, MD, and James W. Jefferson, MD, Madison
173 Wisconsin wrestling minimum weight project
by Ron L. Harms, MD, Shawano

Socioeconomic

179 Primary care physician burnout: definitions, self-assessment and treatment
by David L. Schidermayer, MD, and Bonnie J. Tesch, MD, Milwaukee
183 *Public health*
The smoking continuum in Wisconsin, 1990
by David W. Wetter, MS; Patrick L. Remington, MD; and Gianfranco Pezzino, MD, Madison

Organizational

187 Angel on snowshoes: Kate Pelham Newcomb, MD, 1886-1956
by LeeAnn Kahlor, Milwaukee
188 County society news
191 A glimpse into our past
by Richard D. Sautter, MD, *medical editor*
193 Physician briefs
193 Obituaries
196 William Hocking, MD, wins the 1992 *WMJ* photo contest
198 CES Foundation donors

Our cover: "Sunrise on Bearskin Lake," by William Hocking, MD, of Marshfield, won first place in the 1992 *WMJ* physician photo contest. See the related story on page 196.

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's page

Health care financing reform in Wisconsin: Prescription for the future

'Medicina nusquam non est' (medicine is universal): XI

Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveler, long I stood
And looked down one as far as I could
To where it bent in the undergrowth...
–from "The Road Not Taken"
by Robert Frost

As we approach potential solutions to our health care financing problems in the 1990s, perhaps we should heed the words of Robert Frost. (As an undergraduate, I experienced this Yankee poet laureate as he lectured on American literature.) We should objectively and respectfully evaluate the problems of access to cost-effective, high-quality health care–and we must be prepared to chart different, even unique, courses to achieve effective changes. Simple solutions tend to be what they are–superficial.

As I detailed in this column last month, we have in Wisconsin an excellent and cost-effective health care system, which by many measures leads the country. In spite of this success, however, we do have the problem of unevenness of care, with an increasing lack of obstetric, primary care and hospital services in some of our rural and inner city areas.

Even though Wisconsin has one of the lowest percentages of uninsured in the country, we should be ashamed that any of our citizens are unable to access the health care system. As physicians, we must mobilize the political and moral will power to ensure that at least basic health care is accessible to all.

Placing blame or pointing fingers for any shortcomings of our health care system is counter-productive. As the late Sam Rayburn once said, "Any jackass can kick in a barn door, but it takes a carpenter to build one." All of us should accept our obligation to work together to ensure access to quality health care. Agreement on this goal needs to be achieved before we can move forward.

An adequate health care funding system to ensure access is not just a right, but a responsibility that we must all accept. Unfortunately, it is not yet clear that Americans have arrived at this consensus. Too often, Americans want the best, want it now, but want someone else to pay for it. (A vivid example of this is the recent repeal by Congress of the Medicare Catastrophic Care Act. An action spear-headed by well-to-do retirees.)

As leaders in health care, physicians must help mold public awareness of the need to improve the funding system and to sew up the big holes in the funding net (or get a new net). All of the players need to be motivated and involved, and to pay their part: individual citizens, politicians, insurance companies, pharmaceutical manufacturers, medical schools, hospitals, physicians and allied health personnel.

At its best, American medicine is a world leader; ensuring access to this system is the problem. The bits of a national health care system we already have in

Cyril M. "Kim" Hetsko, MD

this country–Medicare and Medicaid–have been an absolute disaster. As we have learned from other countries, total centralized governmental control often leads to a lack of innovation, stagnation of thought, and misallocation of resources.

The federal and state governments do need, however, to have a strong role in leveling out and tightly regulating the playing field and making certain that we all fulfill our obligations.

It will be worthwhile to borrow parts of the German system (and systems in other nations), and incorporate these into an evolving and uniquely American system.

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Health care funding improvement for our citizens should include:

- some individual fiscal responsibility;
- employer funding obligations;
- community underwriting, with elimination of exclusions for pre-existing conditions;
- portability of coverage to different jobs, or when unemployed;
- sweeping tort reform to save premium costs and defensive medicine costs;
- cost-effective preventive medicine;
- incentives for primary, prenatal and obstetric care services;
- simplified administrative procedures;
- local negotiation of hospital and physician fees between multiple third-party payers and multiple providers (and, possibly, changes in anti-trust laws to permit this);
- strict oversight of the ERISA self-funded plans;
- elimination of the government Medicare and Medicaid cost-shifting; and
- a basic level of benefits for all.

Based on our experience, it is folly to expect that the Congress in Washington or the Legislature in Madison could be efficient and cost-effective in operating a strong, centrally run system. Our federal and state governments have not been shining examples of fiscal responsibility.

The State Medical Society of Wisconsin has been moving this process of change along, and over the past 2 years has been working with a number of key players in the Health Care Forum (including business, hospitals and insurers) to achieve consensus with the 12-point plan and, we hope, begin to solve these problems in Wisconsin. The AMA has also been active with its 16 proposals for reforms at the national level. Building a door that opens takes time and talent.

The necessary changes to further improve access and financing will fiscally hurt us all to some extent, but, I hope, we will all be more fairly meeting our obligations. We **cannot** tolerate a health care funding system in which basic access is denied to any portion of our society.

Two roads divered in a wood, and I–
I took the one less traveled by,
And that has made all the difference.

Secretary's report

For whom the bell tolls

With the passage of AB 655, Wisconsin has taken the first step toward health care reform. Overall, I think it is a step in the right direction. The bill's provisions for certificate of need and uniform hospital accounting are unfortunate–and we are hoping they will fall to the governor's veto pen–but the bill is basically responsible, incorporating a number of items from the SMS-sponsored 12-point plan and Gov Thompson's small business health initiative. It is gratifying to see so much of the SMS' work come to fruition. While we were doing this, however, just across the river, Minnesota has been moving toward disaster.

At press time, Minnesota was on the verge of passing its new Health Right bill–a misnomer of epic proportions–which should serve as a wake-up call to any Wisconsin physician who still thinks that politics are irrelevant to the practice of medicine, that involvement in county and state medical societies is unnecessary, or that political involvement is beneath them. Were it not that HealthRight has the potential for turning the play of health care reform into a tragedy, it would be a comedy of errors. It is a medical Murphy's Law, with unfortunate consequences for the entire population of our neighbor state.

In a nutshell, if the law passes (it is expected to) the state government in Minnesota will set up an insurance company that will have its premiums subsidized by a 2% tax on services offered by doctors and hospitals. It will also set up a commission (25 members, only one of whom will be a physician) to control health care costs by limiting the number of specialists in the state and limiting the availability of advanced, life-saving medical technology. Most alarming, this commission would set arbitrary limits on

Opinion policy

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how much money will be spent each year on medical care.

In case you missed it, that's a polite way of saying "health care rationing."

HealthRight will put an immediate freeze on all new technology and new procedures and require that purchases for any innovation be approved by the commission. While reducing unnecessary duplication of technology is a worthy goal, setting up a "Ministry of Medicine" is not the best way to pursue it. I see four major weaknesses in this plan.

First, the commission's premise is faulty. The creators of the commission obviously believe the myth that all new technology and new procedures translate into higher health care costs. Working from this base, how likely will the commission be to recognize when a technological or procedural advance will be more efficient-both in cost and in healing-than current equipment or methods?

The second weakness is related to the first: With only one physician member, how likely will the commission be to understand-much less accurately evaluate-the technology or procedures it considers? The press, public and politicians have been unable to grasp even as simple a medical message as "you can't get AIDS from casual contact," so how are they supposed to appraise the full costs and benefits of the complexities of medical science?

Third, by definition, the commission's approval of new technologies and procedures will be directly related to its own health care spending limits. Those limits will be, also by definition, determined as much-if not more-by political pressures than by actual medical need. The message to the people of Minnesota is: Your health, your very life, is worth *X* amount, not a penny more, and that variable will change according to political whims and power struggles. If we need to balance a budget, your life may be worth considerably less.

Thomas L. Adams, CAE

The fourth weakness also involves politics. Experience with Medicare and Medicaid has taught us that when government gets involved with health care fund-

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ing, health care itself becomes a political tool. The allocation of health care dollars is often heavily influenced by the political ambitions and social philosophies of the folks holding the purse strings. Considerations of the effects on public health are far down the list of priorities, if they are on the list at all. Anyone who thinks that Minnesota's commission will be free from political pressures when it is deciding which community and which health care facilities will be allowed to have which specialists and which technologies is either naive or foolish.

For any one body to do what Minnesota's health care cost containment commission is charged with doing, its members would have to be blessed with uncommon wisdom, impartiality, and compassion, as well as both broadly and highly educated. I know a few, but only a few, people who possess that combination of characteristics.

The 2% tax on health care services to pay for the $200 million plan is bitterly ironic. In an effort to make health care more accessible to its citizens, Minnesota will raise the cost of being sick or injured. It is worth noting that any across-the-board tax falls heaviest on those least able to pay it, so the financially troubled rural hospitals and clinics–and their patients–will suffer the most. Many of these facilities are providing essential health care to their communities on a 2% margin (or less), so it is not unrealistic to wonder whether some of them will be shattered when the twin hammers of this tax and mandatory Medicare assignment fall. (Yes, mandatory assignment is part of the bill.)

Of course, there is also a philosophical question here: Are we ready to abandon the general principle of keeping life's necessities tax-free? Or are we ready, now that some sectors of society are willing to see health care rationed, to redefine medical care as "unnecessary"? Rep. Paul Ogren, one of HealthRight's developers, has stated that it is a matter of "priorities whether people decide to buy health care," so I guess he has decided that health care is unnecessary. And it appears that the majority of Minnesota's Legislature, as well as the governor, agree with him. I'm sorry, I can't.

Which brings me to my final criticism of HealthRight: It is not the "universal" health insurance it is touted to be. While it will give Minnesota universal access to health insurance, it will also cost them quite a bit of money–and money is not a universal commodity among Minnesota's working poor, who are most of the potential consumers. In Minnesota, as elsewhere, most of the uninsured are part of a working family, but they are working for employers who do not provide coverage and for wages that do not allow them to pay HealthRight's premiums, deductibles and co-payments.

Although it may be years before the full extent of damage to Minnesota's health care system is known, the HealthRight bill should be a warning bell to Wisconsin's physicians and citizens alike, alerting us to get involved if we haven't been and increase our efforts if we have. If it can happen next door, it can happen at home. Ask not for whom the bell tolls, it tolls for thee.[150th]

Letters

Cholecysto-sternal fistula

To the editor: The patient, a pleasantly confused 87-year-old woman, was seen in June 1990 with an abscess overlying the inferior sternum. This had not been noted on an unrelated admission 3 months before. The area was incised and drained of "1.5 cups of pus." Treatment by packing and with antibiotics did not result in healing. Two months later, the tract was widely excised down to the sternum and again packed. Group D streptococcus and enterococcus were cultured.

Several times there appeared to be healing, but each time the wound broke down. In March 1991, a sternal sinusgram revealed that there was a sinus tract communicating with the gallbladder and that a large stone was present. This was confirmed with a CT of the abdomen which was reported as showing "the fistula beginning just above the junction of the xiphoid and sternum and extending laterally, first in the musculature of the anterior abdominal wall and then beneath it and directly to the most anterior portion of the gallbladder and filling into the gallbladder outlining several large lucent stones." An upper GI series revealed no evidence of fistulous communication between the duodenum and gallbladder despite gross inflammatory changes. Other studies revealed a normal complete blood count and chemistry panel including liver function studies. At no time had the patient ever had gastrointestinal complaints.

In April 1991, the patient underwent a cholecystectomy and excision of the cholecysto-cutaneous fistula through two incisions by Filomen Yao, MD. The gallbladder was removed in three fragments along with a large calculus. Dense adhesions were encountered. The sternal incision was closed loosely and with drainage. The post-operative course was uneventful and the patient returned to her nursing home. Nine months later, there had been no recurrence or other problem.

A computerized search of the literature of the past 10 years turned up nothing like this case, although there were several reports of fistulous tracts between the gallbladder and lung or pleura. These occurred mainly in South America from parasitic infections.

–Victor Falk, MD
Edgerton[150th]

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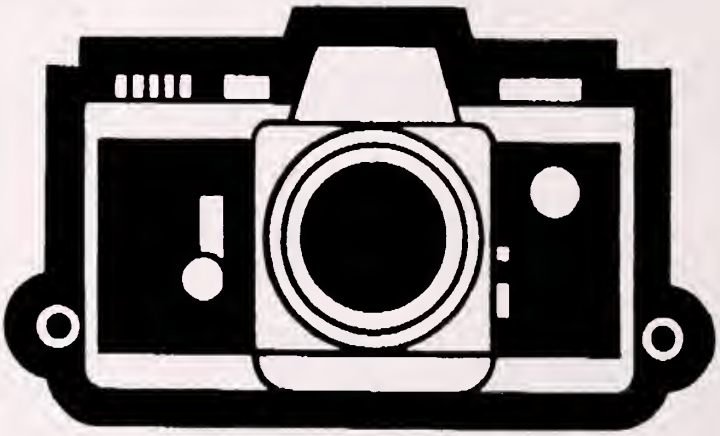

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The *WMJ* cannot be responsible for entries—so do not send your only copy.

Deadline: All entries must be postmarked no later than February 14, 1993. Send entries to: Photo Contest, *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.

Antidepressant medication and suicide

John H. Greist, MD, and James W. Jefferson, MD, Madison

Depression is an affliction affecting at least 5% of the general population at any time and 15% at sometime during their lives.[1] In addition to dysphoric or depressed mood, distress and dysfunction result from some combination of loss of interest in important activities, inability to experience pleasure, significant appetite and sleep disturbance, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or inappropriate guilt, and diminished ability to think or concentrate (Table 1).[2] This morbidity takes its toll on families and the larger community, as well as the patient.

The financial cost of depression is staggering. The National Institute of Mental Health estimated the cost in 1989 to be $27 billion ($10 billion in medical costs and $17 billion in absenteeism).

Depression also has a significant mortality through suicide with 15% of depression sufferers taking their lives during one of the recurrent episodes they typically experience.[3] Despite this high cumulative death rate from suicide, the risk of suicide in any given episode remains comparatively small although increased several fold over the risk for nondepressed people. Currently, we have no precise predictors of suicide risk and it is neither feasible nor legal to confine depressed patients or even most of those with thoughts of suicide until they recover.

Although still crude, the best clinical indicators of increased suicide risk over the next year are anhedonia, global insomnia, psychic anxiety, panic attacks, decreased concentration and alcohol abuse. Suicidal ideation, previous suicide attempt(s) and hopelessness are probably the best long-term (more than 1 year) predictors of suicide risk.[4]

Hospitalization is reserved for patients with thoughts of suicide who also have active suicide plans, limited support systems and poor impulse control. On average, an episode of depression lasts approximately 9 months (the range is large, from as little as 2 weeks to many years) so the best way to reduce suicide in depressed patients is to reduce the duration and severity of the depressive episode. Fortunately, there are several effective treatments for depression which can shorten the time of high suicide risk.

Table 1.–Manifestations of depression.

Mood (Affect)	**Cognitive**
sad, depressed, "blue," unhappy	loss of interest
apathetic	difficulty concentrating
irritable	indecisiveness
anxious	hopelessness and helplessness
	low self-esteem and worthlessness
	guilt
	suicidal ideation
Behavioral	**Somatic**
slowed, retarded	appetite decrease or increase
restless, agitated	weight loss or gain
crying	insomnia or hypersomnia
withdrawn	fatigue
dependent	decreased sex drive
suicidal	gastrointestinal upset
	aches and pains

Dr Greist and Dr Jefferson are with the University of Wisconsin-Medical School, Department of Psychiatry. Reprint request to: John H. Greist, MD, Dept. of Psychiatry, Clinical Sciences Center, 600 Highland Ave, Madison, WI 53792-2475. Copyright 1992 by the State Medical Society of Wisconsin.

Psychotherapies

Cognitive behavior therapy and interpersonal psychotherapy have been shown to be effective treatments for mild to moderate depression.[5]

Both of these techniques require training and more time (10 to 20 hours over approximately 3 months) than most primary care physicians can provide. If patients have mild or moderate depression, referral for these treatments is appropriate. Severity of depression can be estimated using patient self report measures such as the Beck Depression Inventory, the Zung Depression Rating Scale or the computer version of the Hamilton Depression Rating Scale (Table 2).[6]

Every physician can and should provide supportive psychotherapy for patients receiving other specifically effective treatments for depression. While the label "supportive psychotherapy" sounds complicated, it embodies elements of good care that all clinicians employ. Patients need an understanding of their disorder; empathy for the distress they are experiencing; and hope they can recover (as most depressed people do).

Antidepressant medications

The introduction of tricyclic and monoamine oxidase inhibitor antidepressants in the late 1950s provided the first predictably effective pharmacologic treatment for depression. Although operating through different mechanisms, these two classes both enhance neurotransmission of important brain amines.

While theorists often emphasize a particular neurotransmitter, it is probable that the major measurable effect on single neurotransmitters creates a cascade of secondary effects across at least some of the 60 or more brain neurotransmitters and neuromodulators which combine to produce an antidepressant effect. Thus, antidepressant medications with markedly different primary mechanisms of action exhibit remarkably similar therapeutic effectiveness.

Side effect profiles, however, do differ in relation to anticholinergic, antihistaminic or alpha-adrenergic effects prominent with many of the earlier antidepressants. Table 3 lists antidepressant medications available in the United States. While clomipramine (Anafranil) does not have an indication for treatment of depression in the United States, it has been used as an antidepressant since 1966 and is approved for that indication in more than 70 countries. Table 4 lists monoamine oxidase inhibitors used as antidepressants.

Characteristics of an ideal antidepressant include rapid onset of therapeutic effect, low-cost, minimal or easily tolerated side effects, simple dosing regimen and safety in overdose (patients often use these medications as their mode of suicide). Thus far, no compound has unequivocally demonstrated more rapid onset of antidepressant effect. While the older antidepressants are tolerated by many patients, it is clear that the newer agents have less severe side effect profiles and a broader range of acceptance. Most antidepressant medications (bupropion is an exception) can be taken in a single daily dose. Bupropion, fluoxetine, sertraline and trazodone are substantially less lethal in overdose than tricyclic antidepressants, with clomipramine being the safest of the tricyclics.[7]

Recently, an alarm was raised that fluoxetine (Prozac) may be linked to an increased risk of suicide.[8] This report led to widespread airing of sensationalized personal testimonials. The fundamental issue of the risk of worsening or lessening suicidal ideation and behavior in depressed patients was temporarily obscured by the popular press' predictable pattern of publishing controversial opinion and speculation rather than waiting for reasoned conclusions based on careful review of available data. Currently, a clearer picture is emerging from analyses of controlled research studies of fluoxetine as well as a broader review of the issue of associations between all antidepressant medications and suicidal ideation and attempts.

Paradoxical worsening of suicidal ideation and behavior has been associated with antidepressant pharmacotherapy. Case reports[9,10] describe such worsening. These are, however, idiosyncratic and paradoxical responses and exceptions to the well-established observation that treatment of depression lessens suicidal ideation and behavior.

As fluoxetine is a potent and selective serotonin uptake inhibitor, one might wonder whether antidepressants with this primary mechanism of action may be more likely than other antidepressants to induce worsening of suicidal phenomena. Available evidence from studies of three different serotonin uptake inhibitors (citalopram, fluvoxamine, zimelidine) does not support this hypothesis. Mann and Kapur reviewed evidence from six double-blind studies comparing selective serotonin uptake inhibitors with other antidepressants and found that in four studies, the serotonin uptake inhibitor conveyed earlier lessening of suicidality (although

Table 2.–Patient self-rating scales.*

Rating scale	Format	Source
Beck Depression Inventory	paper-and-pencil, hand-scored and computer-scored	Psychological Corporation
Hamilton Depression Rating Scale	computer-administered, computer-scored, can be used sequentially	Kenneth Kobak, University of Wisconsin
Zung Depression Scale	paper-and-pencil, hand-scored,	

*From reference 17.

the differences were no longer present at 6 weeks).[11]

With regard to fluoxetine, a retrospective meta-analysis of clinical trial data assessed changes in the suicide ideation item (number 3) of the Hamilton Depression Rating Scale for 3,065 patients treated with fluoxetine (n=1765), a tricyclic antidepressant (n=731) or placebo (n=569). Item 3 is scored as follows: 0 = no suicidal ideation; 1 = doubtful or trivial ideation; 2 = mild ideation; 3 = active ideation and suggestive behaviors; 4 = severe ideation usually involving an act. The emergence of substantial suicidal ideation (defined by a change in Item 3 from 0-1 at baseline to 3-4 during treatment) occurred less often with fluoxetine (1.2%) than with placebo (2.6%) ($p = 0.042$) or tricyclic antidepressants (3.6%) ($p = 0.001$).[12]

Worsening of previously present suicidal ideation (defined as an increase in Item 3 score during the course of treatment) occurred equally across the three treatment conditions: fluoxetine 15.3%, placebo 17.9% and tricyclics 16.3% with no statistically significant differences (fluoxetine v placebo $p = 0.141$ and fluoxetine v tricyclic antidepressants $p = 0.542$). Most importantly, improvement in suicidal ideation occurred in 72.2% of fluoxetine-treated patients, 54.8% of patients receiving placebo and 69.8% of those given tricyclic antidepressants. Fluoxetine improved suicidal ideation significantly more than placebo ($p<0.001$) but not more than tricyclic antidepressants ($p = 0.296$) (Table 5).

For those few patients who may experience increased suicidal ideation while taking fluoxetine, severe akathisia (anxiety and physical restlessness) may be an important associated factor.[13] Recognition of akathisia should lead to increased monitoring and if severe, to discontinuation of fluoxetine or treatment of the akathisia with a beta-blocker. Akathisia related to antipsychotic drug treatment has also been associated with suicidal behavior.[14-16]

Recently, (Sept 20, 1991), the FDA Psychopharmacological Drugs Advisory Committee met to discuss the issue of antidepressant drugs and suicidality. "The committee unanimously agreed that there was no credible evidence of a causal link between the use of antidepressant drugs, including Prozac, and suicidality or violent behaviors."[17]

For most patients, antidepressant medications decrease suicidal ideation and suicide risk more than placebo or, presumably, no treatment. Even in situations when suicidal ideation increases during treatment with antidepressants, it would be difficult to prove that this was caused by the drug as opposed to being merely associated with treatment that has not yet become effective. It is possible, of course, that rare idiosyncratic reactions do occur, and for this reason clinicians should remain alert to the possibility.

Because 15% or more of depressed patients will have worsening of suicidal ideation and a small percent may have emergence of suicidal ideation during treatment with antidepressant medications, it is critically important that de-

Table 3. – Cyclic antidepressant medicines.*

Agent		Usual daily starting** dose (mg)	Usual effective daily dose (mg)	Relative sedative effects	Relative anticholinergic effects	Relative hypotensive effects
Generic name	**Trade name**					
Tricyclic antidepressants						
amitriptyline	Endep Elavil Amitid	50-75	150-300	high	high	more
amoxapine	Asendin	50 three times daily	150-400	medium	low	less
desipramine	Norpramin Pertofrane	50	100-300	low	low	more
doxepin	Sinequan	50-75	75-300	high	medium	more
imipramine	Janimine SK-Pramine Tofranil	50-75	150-300	medium	medium	more
nortriptyline	Aventyl Pamelor	25-50	50-100	low	medium	less
protriptyline	Vivactil	5 three times daily	15-60	low	high	more
trimipramine	Surmontil	50-75	50-200	high	medium	more
Other antidepressants						
bupropion	Wellbutrin	75-100 twice daily	300-450	low	low	less
fluoxetine	Prozac	20	20-40	low	low	less
maprotiline	Ludiomil	50-75	125-225	medium	low	less
sertraline	Zoloft	50	50-200	low	low	less
trazodone	Desyrel	50 three times daily	150-400	high	low	less

*From reference 17.
**Lower doses (often 1/3 to 1/2 of the usual dose) are used with older patients.

Table 4.–Monoamine oxidase inhibitor antidepressants*

Generic name	Trade name	Usual starting dose	Usual therapeutic daily dose
isocarboxazid	Marplan	10 mg twice daily	30-40 mg
phenelzine	Nardil	15 mg twice daily	60-90 mg
tranylcypromine	Parnate	10 mg twice daily	30-60 mg

*From reference 17.

Table 5.–Fluoxetine and suicide.

Suicidal ideation-emergence
FLU 1.2%, PBO 2.6%, TCA 3.6%
Suicidal ideation-worsening
FLU 15.3%, PBO 17.9%, TCA 16.3%
Suicidal ideation-improvement
FLU 72.2%, PBO 54.8%, TCA 69.8%

(Beasley et al. *Brit Med J* 1991;303:685-692)
FLU = fluoxetine; PBO = placebo;
TCA = Tricyclic antidepressant

pressed patients have continued monitoring and ready access to repeated evaluations and alternative treatments, including hospitalization, if they become necessary. Antidepressant medications lessen suicide risk but they do not eliminate it. Patients, family members and physicians must not be lulled into a false sense of security because depression has been diagnosed and treatment initiated with antidepressant medication. Patients and family members often want and benefit from information they can read and reread regarding depression and its treatments.[18]

To ensure effectiveness, antidepressants must be given in sufficient dose (Table 2) and duration (6-8 weeks). Once a patient responds and full remission is attained, treatment should usually continue for 4 to 6 months before consideration is given to gradual dosage reduction and discontinuation. If depression is recurrent, maintenance of long-term antidepressant treatment is often indicated.

Electroconvulsive therapy

Electroconvulsive therapy (ECT) remains an effective treatment for severe depression.[19-21] In fact, many psychiatrists feel it is the most effective treatment for severe depression and the definitive treatment for psychotic depression.[22] Although cumbersome to use and correspondingly costly over the short-term, ECT's rapid effectiveness in depressions which fail to respond to other treatments has led to renewed use of this modality for carefully selected cases. For those who are medically unstable, ECT probably presents fewer risks than tricyclic or monoamine oxidase inhibitor antidepressants although newer compounds such as bupropion, fluoxetine and sertraline may be better tolerated by those who are medically less robust.

Conclusion

Depression is a common and distressing malady. Suicidal ideation and acts frequently accompany depression. Antidepressant treatments usually produce remission of depression within weeks with concomitant lessening or elimination of suicidal aspects of the disorder. Some patients, however, have onset or worsening of suicidal ideation after antidepressant treatment begins. Comprehensive care of the depressed patient includes alerting them and, where possible, significant others, about these possibilities so that further assessments and modification of treatment can be made if indicated. Overall, antidepressant treatment with medications and other modalities lessens the major morbidity that is common in depression and reduces the risk of suicide–depression's main mortality.

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Wisconsin wrestling minimum weight project

Ron L. Harms, MD, Shawano

Starting in the 1991-1992 school year, Wisconsin was the first state to have a mandatory minimum weight established for high school wrestlers, along with a comprehensive standardized nutrition education program. The minimum weight project was phased in over 2 years. The goal of the project is to scientifically predict a healthy minimum weight for high school wrestlers. No guidelines were previously set and unhealthy weight loss practices are sometimes used to achieve desired weights. A wrestler's weight is often determined by the need to fill a wrestling class and not on a good scientific basis. Many wrestling coaches across the state have tried to implement individual programs, but until this project there had been no coordinated, collective effort. *Wis Med J.* 1992;91(4):173-175.

As of October 1991, body fat percentages are being determined for all Wisconsin high school wrestlers by Wisconsin Interscholastic Athletic Association (WIAA) trained and certified measurers. If, at that time, a male wrestler has below a 6% body fat and a female wrestler is less than 12% body fat, the wrestler must obtain a physician's clearance that this is a natural body fat percentage for him or her. Most high school male wrestlers have between 9% and 11% body fat, and most females have between 15% and 20% body fat. A 7% body fat with 3% of predicted weight allowance will be used to establish a minimum weight for the wrestling season. From our studies, and other studies done across the country, only 1% to 2% of high school males have below 6% body fat naturally. Thus, out of the approximately 7,000 high school wrestlers in Wisconsin, only 70 to 100 will naturally fall below 6% body fat. For the health and well being of high school wrestlers, it is important that physicians make an accurate assessment of the high school wrestler who falls below the 6% body fat, so as to ensure that they are able to have normal growth and development.

As mentioned above, a critical part of this project is a standardized nutrition education program, which has been developed by the WIAA, consultants across the country, the Wisconsin Dietetic Association and the Department of Public Instruction. The Wisconsin Dietetic Association not only helped develop the material to be taught, but also cooperated with the WIAA in training and certifying dietitians across the state. These trained individuals will be available for nutrition education sessions for coaches, wrestlers, and their families.

A copy of the WIAA rule for high school wrestling is printed on the following page and summarizes the minimum weight project. This may answer questions from high school wrestlers, their parents, or their coaches.

The WIAA appreciates the support of Wisconsin's physicians in this project and welcomes any suggestions for improvement.

For questions or for more information, contact Ron Harms, MD, West Side Clinic, 1551 Dousman St, PO Box 19070, Green Bay, WI 54307, or Don Herrmann,

Reprint requests to: Ron Harms, MD, West Side Clinic, 1551 Dousman St, PO Box 19070, Green Bay, WI 54307. Copyright 1992 by the State Medical Society of Wisconsin.

assistant director, Wisconsin Interscholastic Athletic Association, 41 Park Ridge Dr, Stevens Point, WI 54481 (or call 715-344-8580).

WIAA minimum weight rule

The establishment of a minimum wrestling weight based on 7% body fat for males and 12% for females will be mandatory for all senior high school wrestlers beginning with the 1991-1992 season. The WIAA does not advocate that a wrestler's established minimum weight is the athlete's best weight, but simply the minimum weight at which the athlete will be allowed to compete.

I. Establishing minimum weights
   A. Skinfold measurements will be utilized to determine each wrestler's body fat percentage. Only measurements taken by health care professionals who have successfully completed the WIAA Skinfold Measurement Workshop will be accepted.
      Schools will receive a list of approved measurers. It is the responsibility of the school to contact a skinfold measurer from this list, and arrange a time to have the wrestling squad measured. No senior high wrestler may compete until the athlete has had a minimum weight determined.
   B. The lowest weight class a wrestler may compete at will be determined as follows:
      1. If the predicted weight is exactly that of one of the weight classes that shall be the wrestler's minimum.
      2. If the predicted weight falls between two weight classes.
         a. When the minimum predicted weight is above the mid-point between two weight classes, he must wrestle at the higher weight class.
         b. When the minimum predicted weight is equal to or below the mid-point between two weight classes with written parental permission the wrestler will be allowed to compete at the lower weight. Without such written permission, the wrestler must wrestle at the high weight class.
         c. Wrestlers whose body fat percentage fall below 7% at the time of measurement may not wrestle below their predicted minimum weight. (Rules 2.a. and b. above do not apply.)

II. Time period for measurements
   A. Skinfold measuring may begin on the third Monday of October (October 21 for the 1991-1992 season). Wrestlers may be measured any time on or following this date. There is no deadline for measurement. All wrestlers, including those coming out late, must have their minimum weight established prior to competing. The school will receive, from the skinfold measurer, the skinfold measurement results with 72 hours (three working days) of the time of the measurement.
   B. If initial participation and skinfold measurements occur after December 25, the wrestler must make scratch weight.

III. School responsibilities for the measurement process
   A. It is the school's responsibility to contact an approved measurer from the list provided by the WIAA.
   B. The school must have available at the time of the skinfold measuring:
      1. A certified scale (certified after the start of school in the fall and before October 21).
      2. An accurate means of measuring each wrestler's height to the nearest 1/2".
      3. Skinfold data forms.
      4. A school office (eg, coach, teacher, A.D.) who will:
         a. Assist with obtaining height and weight of each wrestler.
         b. Assist with the recording of data.
   C. It is the school's responsibility to send, within one working day, a copy of all skinfold results (printout received from skinfold measurer) to the WIAA

IV. Wrestlers below 6% body fat
   A. Any male wrestler whose body fat percentage at the time of measurement is below 6% must obtain in writing a licensed physician's clearance stating that the athlete is naturally at this sub-6% body fat level. In the case of a female wrestler, written physician's clearance must be obtained for athletes who are sub-12% body fat.

V. Growth allowance
   A. Growth allowance will be reinstated. Two pounds will be allowed on December 25, and one pound on February 1.

VI. Weight loss per week
   A. A weight loss limit of three pounds per week has been set. The projected earliest date to wrestle at the predicted minimum will be broken down into days. This date will appear on the printout received from the skinfold measurer.
   B. A wrestler will not be allowed to wrestle at any time in a weight class that would require him to lose more than three pounds per week from the original date of measurement.

VII. Appeal process
   A. Any athlete may appeal their skinfold measurements or calculations. The steps of the appeal process are as follows:
      Step 1: All mathematical calculations are recomputed by the skinfold measurer.
      Step 2: If still dissatisfied with the results, the wrestler is remeasured by the same skinfold measurer. The wrestler chooses which measurement to accept (the original or the second measurement).
      - This step must be completed within 14 days of the original measurements.
      - Step 1 must be performed prior

to Step 2.

- The original weight will be used in the calculations. Only the skinfold measurements will be retaken.

Step 3: If still dissatisfied with the results the wrestler may choose to be hydrostatically weighed to determine body fat percentage. Results obtained at this step are automatically accepted; the athlete has no choice.

- Hydrostatic weighing facilities must be approved by the WIAA
- This step may be performed at anytime prior to the individual athlete's first varsity competition.
- Steps 1 and 2 may be by-passed and only Step 3 performed.

VIII. Nutrition education program

A. While not mandatory, it is highly recommended that each school participate in the nutrition education aspect of the project.

IX. Costs

A. All costs incurred for the initial skinfold measurement, appeal process, and nutrition education program are the responsibility of the school.[15pt]

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* See DOSAGE AND ADMINISTRATION section of prescribing information.

† If, after an adequate trial of ACCUPRIL alone, based on your medical judgment as the prescribing physician, you determine that your patient requires the addition of a diuretic, Parke-Davis will refund to the patient his/her cost for the diuretic prescription less any amount reimbursed or paid for by an HMO, insurance company, or any other plan or program.

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‡ In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Please see brief summary of prescribing information on following page.

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PARKE-DAVIS

Accupril® (Quinapril Hydrochloride Tablets)

Before prescribing, please see full prescribing information. A brief summary follows.

INDICATIONS AND USAGE

ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics.

In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

CONTRAINDICATIONS

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

WARNINGS

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment, antihistamines may be useful in relieving symptoms.

Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).

Hypotension: Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N = 3203); this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

Fetal/Neonatal morbidity and mortality: ACE inhibitors, including ACCUPRIL, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios has been associated with fetal limb contractures, craniofacial deformities, hypoplastic lung development, and intrauterine growth retardation.

Prematurity and patent ductus arteriosus have been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure or to the mother's underlying disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

A patient who becomes pregnant while taking ACE inhibitors, or who takes ACE inhibitors when already pregnant, should be apprised of the potential hazard to her fetus. If she continues to receive ACE inhibitors during the second or third trimester of pregnancy, frequent ultrasound examinations should be performed to look for oligohydramnios. When oligohydramnios is found, ACE inhibitors should generally be discontinued.

Infants with histories of in utero exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Hemodialysis and peritoneal dialysis have little effect on the elimination of quinaprilat and quinaprilat.

No fetotoxic or teratogenic effects were observed in rats at quinapril doses as high as 300 mg/kg/day (180 and 30 times the maximum daily human dose when based on mg/kg and mg/m², respectively), despite maternal toxicity at 150 mg/kg/day. Tested later in gestation and during lactation, reduced offspring body weight was seen at ≥25 mg/kg/day, and changes in renal histology (juxtaglomerular cell hypertrophy, tubular/pelvic dilation, glomerulosclerosis) were observed both in dams and offspring treated with 150 mg/kg/day. Quinapril was not teratogenic in the rabbit, however, as noted with other ACE inhibitors, maternal toxicity and embryotoxicity were seen in some rabbits at quinapril doses as low as 0.5 mg/kg/day (one time the recommended human dose) and 1.0 mg/kg/day, respectively.

PRECAUTIONS

General

Impaired renal function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

Evaluation of hypertensive patients should always include assessment of renal function (see DOSAGE AND ADMINISTRATION).

Hyperkalemia and potassium-sparing diuretics: In clinical trials, hyperkalemia (serum potassium ≥5.8 mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

Surgery/anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Angioedema: Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

Symptomatic hypotension: Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

Hyperkalemia: Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

Accupril® (Quinapril Hydrochloride Tablets)

Neutropenia: Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Concomitant diuretic therapy: As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

Agents increasing serum potassium: Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

Tetracycline and other drugs that interact with magnesium: Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

Lithium: Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

Other agents: Drug interaction studies of ACCUPRIL with other agents showed:

- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril coadministration twice-daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on a mg/m² basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilat were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro* chromosome aberration with V79 cultured lung cells, and in an *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m², respectively).

Pregnancy

Pregnancy Category D: See WARNINGS, Fetal/Neonatal morbidity and mortality.

Nursing Mothers

It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in milk of lactating rats (5% or less of the plasma drug concentration was found in rat milk). Because many drugs are secreted in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

Geriatric Use

Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinaprilat compared to values observed in younger patients, this appeared to relate to decreased renal function rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

Pediatric Use

The safety and effectiveness of ACCUPRIL in children have not been established.

ADVERSE REACTIONS

ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below.

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuance)	Placebo (N = 579) Incidence (Discontinuance)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N = 4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the last events are in italics) include (listed by body system):

General: back pain, malaise

Cardiovascular: palpitation, vasodilation, tachycardia, *heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances*

Gastrointestinal: dry mouth or throat, constipation, *gastrointestinal hemorrhage, pancreatitis, abnormal liver function*

Nervous/Psychiatric: somnolence, vertigo, syncope, *nervousness, depression*

Integumentary: increased sweating, pruritus, *exfoliative dermatitis, photosensitivity reaction*

Urogenital: *acute renal failure*

Other: amblyopia, pharyngitis, sinusitis, bronchitis, *agranulocytosis, thrombocytopenia*

Angioedema: angioedema has been reported in patients receiving ACCUPRIL (0.1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Clinical Laboratory Test Findings

Hematology: (See WARNINGS)

Hyperkalemia: (See PRECAUTIONS)

Creatinine and blood urea nitrogen: Increases (>1.25 times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often resolved on continued therapy.

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Primary care physician burnout: definitions, self-assessment and treatment

David L. Schiedermayer, MD, and Bonnie J. Tesch, MD, Milwaukee

THE AMA DEFINES an impaired physician as a physician who is "unable to practice medicine with reasonable skill and safety to patients because of physical or mental illness, including deteriorations through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol."[1]

Impairment

Impairment has also been defined as at the end of a stress continuum leading from normal to increased stress to burnout to impairment. For physicians, stress begins before medical school and increases in medical school.[2] In medical school the traits of obsessive compulsiveness, delayed gratification, competitiveness, and personal sacrifice are important.[3] A sense of peer rivalry begins. Sleep needs are neglected, personal free time is limited, and work life is compartmentalized from home life and emotional life. Financial difficulties are often severe.

During residency, these stresses continue and worsen. Residents are frequently exposed to negative peer review. Financial constraints continue. Depression and sleep deprivation and disturbances are common. The data show that clinical depression exists in 30% of interns, and more than a third of the depressed physicians consider leaving medicine altogether.[4]

But then comes medical practice: A practicing physician is expected to be a community and social leader. He or she is also a business person, who must deal with external pressures from insurance companies, lawyers, government agencies, hospital administrators, and peer competition. Paperwork and economic pressures build up. The stacks of paper on physicians' desks grow large–lab and x-ray reports to review, home health care forms to sign, HMO communications, etc. Some authorities on the subject say that the two largest stressors for physicians are administrative: government regulations and paperwork.[5]

The next three stresses are malpractice, negotiations with third party payers, and regulatory agencies. Then, if physicians earn a good clinical reputation, they may be simply overloaded with work and find it difficult to juggle all the other priorities in their lives, including personal, family, and spiritual needs.[6]

Burnout

Stress leads to burnout, and burnout can lead to impairment. Burnout is defined as the "process by which a once committed health professional becomes ineffective in managing the stress of frequent emotional contact with others in the helping context, experiences exhaustion, and as a result disengages from patients, colleagues, and the organization."[7] Psychologically, the burned-out physician becomes apathetic and critical of others. He or she may depersonalize patients and may have feelings of low personal accomplishment.[8] Common professional responses to burnout include spending less time with patients, tardiness, absenteeism, medication errors, poorly charted observations, impersonal or stereotyped communication with patients, search for relocation, and inefficient patient care.[7]

Self-assessment

Are you at risk for burnout and impairment? We will give you a 10-question check list which assesses the possible existence of burnout.[3] This is not a detailed psychological evaluation, and we urge those of you who complete this questionnaire to seek further help if indicated. The SMS has taken a supportive approach to impaired physicians.[9] Physicians with further questions should called the Impaired Physician Program at 608-257-6781 or 800-362-9080.

Please answer yes, no, or sometimes to the following 10 questions:

1. Do you drink alcohol, smoke cigarettes, or eat more than is normal for you?
2. Do you have insomnia?
3. Have you become cynical about the "system," always finding fault with the way things are?

Continued on next page

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Continued from preceding page

4. Have you found yourself "taking it out" on your spouse or family members?
5. Have you been dwelling on the amount of money you have amassed or the amount you are making?
6. Are you scheduling more and more vacation periods as avoidance of work?
7. Are you dragging at work, dreading the patient encounter?
8. Have you lost the intrigue with medicine?
9. Are you given to tears or uncontrolled tantrums lately?
10. Have you strongly considered leaving medicine for another career lately?

A "yes" response to 5 of the 10 questions above would place you in the at-risk category for burnout. If you answered "yes" to 6 or more questions your burnout has reached a critical level.

Treatment

One of the first steps in treating burnout is awareness of the problem. To manage the problems of burnout and impairment, a physician must carefully examine his or her stress in terms of family life and professional demands. Then, if the problem is mild, steps must be taken to lighten the loads and reduce the stresses.

If the problem is severe, as in an impaired physician, professional help is often needed. Sometimes impaired physicians fail to recognize their own impairment and require the help of colleagues. As physicians we are responsible to confront our impaired colleagues or report their behavior to appropriate authorities and agencies, or both, so that our colleagues may receive help. The AMA has a complete and helpful packet on impaired physicians.

Several authors have recommended a number of practical solutions to burnout and impairment. Many of these solutions have not been formally tested, but seem sensible.

Solutions

1. Recognize that you are at risk for burnout.[7]
2. Incorporate healthy values into your practices, including respect for the patient as an individual, self acceptance, recognition of personal vulnerability, effective limit setting, acknowledging the natural course of events, and learning to live with uncertainty.[10]
3. Environmental change and time planning are also important. Vacations and weekends away are a means of stress reduction. Try to maintain them without interruption. Calendar planning is essential; hospital com-

Continued on page 182

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Continued from page 180

mittee meetings may coincide with family vacations.

It is helpful to coordinate your work calendar with the family calendar. Eliminate dual commitments, and unessential or unwanted commitments. Provide space for leisure.

Daily change is needed also: Arrange for flexibility of pace and time demands. Build in blocks of time for patient education, CME, etc. Part of time management is to reduce self expectations in terms of numbers of patients seen. Vary your professional activities such as teaching, journal reading, professional writing. Maintain the off day without interruption or phone calls.[3]

4. Reconsider or renew the spiritual aspects of your life.
5. Exercise. It serves as a mental relaxer and can overcome fatigue and increase the quality of sleep. It allows for time alone and a change of mental and physical pace. Exercise also provides an opportunity to unleash aggressive drives in a socially acceptable manner, and to be with others in a non-medical activity.[3] Current recommendations are for 15 minutes of aerobic exercise three times a week.
6. Biofeedback may be helpful for some persons.
7. Regulate your diet. Reducing alcohol and caffeine, and eliminating tobacco, is useful.
8. Increase rest and sleep.
9. Developing a social support system is helpful, but requires time.
10. Also needed is a medical support system where other doctors can listen, provide technical and emotional support, and challenge and hold each other accountable.
11. Professional counseling is often useful–even one or two sessions–in gaining perspective and bringing about some positive changes.
12. Laugh. As Lipp points out, "Few qualities will serve you as well in reducing burnout as a sense of humor. You will be confronted again and again by life's absurdities, and they must be recognized for what they are. Believe in human folly: Wisdom often creeps into our foolishness if we have the wit to see it. And sometimes the reverse also is true: We who aspire to be so wise can often seem foolish and amusing to others. The practice of medicine can be, in addition to everything else, a great deal of fun, but like so much in life, what you get out of it is largely a reflection of what you bring to it."[10]

Conclusion

Impaired physicians fail to practice medicine with reasonable skill. Stress and impairment can begin in medical school and residency. Obsessive-compulsive traits, delayed gratification, competitiveness, and personal sacrifice can predispose to this condition. Paperwork, government regulations, malpractice, and economic pressures can contribute to the stress. Burned out physicians spend less time with patients and provide ineffective and inefficient patient care. Physicians should recognize stress, burnout, or impairment in themselves or in colleagues. Prompt recognition and treatment will help both the physician and his or her patients.

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The smoking continuum in Wisconsin, 1990

David W. Wetter, MS; Patrick L. Remington, MD; and Gianfranco Pezzino, MD, Madison

SMOKING PREVALENCE in the United States decreased from 40% in 1965 to 29% in 1987, largely in response to an increase in the number of persons who quit smoking.[1] Although smoking status is often categorized as a dichotomy of smoking versus non-smoking, smoking per se may be more appropriately conceptualized as a dynamic process in which smokers move back and forth along a continuum. At one end of the smoking continuum are smokers who are not interested in quitting and at the other end are those individuals who have successfully quit smoking and remain abstinent. This report assesses this "smoking continuum" for Wisconsin adults.

Data are from the 1990 Wisconsin Behavioral Risk Factor Survey, a random-digit-dialed telephone survey of the health practices of Wisconsin adults. The smoking status of respondents (n=1224) was classified along a smoking continuum, adapted from one used in the 1989 Surgeon General's Report[1] (Table 1). To be considered as ever being a smoker, a person must have smoked at least 100 cigarettes in his or her lifetime. Observations were weighted to adjust the sample for the estimated age, sex, and race distribution of the population.

To examine the current dynamics of smoking cessation, we compared the proportion of current smokers who have tried to quit smoking (categories 5 through 7) for various demographic subgroups.

Quitting and the smoking continuum

Among all adults in Wisconsin, 48% have never smoked, 28% are former smokers, and the remaining 24% are current smokers (Table 1). About half (49%) of the persons who had ever smoked have quit. Among persons who smoked during the year before the survey, 12% quit and were off cigarettes at the time of the interview–another 31% quit smoking for one or more days. Finally, among current smokers, 71% have tried to quit at some time in the past, and an additional 16% would like to quit if there was an easy way to do so.

Attempts to quit

Table 2 shows the percentage of current smokers who have tried to quit smoking. Compared with older adults, younger persons have higher rates of smoking (14% versus 28%) and, among those who currently smoke, are less likely to attempt to quit (61% versus 86%). Compared with females, males have slightly higher rates of smoking but are more likely to try quitting. Compared with whites, nonwhites have higher rates of smoking but are also more likely to be trying to quit. Finally, less educated persons have higher rates of smoking, but are about as likely to try to quit.

Continued on page 185

Table 1.-The smoking continuum for adults in Wisconsin, 1990.

Category	Description	All adults (n = 1,224)	Ever smokers (n = 633)	1990 smokers (n = 311)	Current smokers (n = 284)
1	*Never smokers*	48%			
2	*Former smokers* who quit 1 of more years ago	25%	49%		
3	*Former smokers* who quit 3 to 12 months ago	2%	3%	7%	
4	*Former smokers* who quit within the last 3 months	1%	2%	5%	
5	*Current smokers* who quit for 7 or more days in past year	5%	9%	18%	20%
6	*Current smokers* who quit for 1 to 6 days in past year	4%	7%	13%	15%
7	*Current smokers* who quit previously, but not in past year	8%	16%	32%	36%
8	*Current smokers* who thought about quitting or would quit if there was an easy way	4%	7%	15%	16%
9	*Current smokers* who have not thought about quitting and would not try to quit, even if there was an easy way	3%	6%	12%	13%

Columns may not add up to 100% due to rounding.

Wetter is a graduate student in the departments of psychology and preventive medicine at the University of Wisconsin-Madison. Dr Remington is with the Bureau of Public Health, Wisconsin Division of Health. Dr. Pezzino is with the bureau and the Centers for Disease Control. Reprint requests to: Patrick Remington, MD, Wisconsin Division of Health, 1400 E Washington Ave, Madison, WI 53703-3041.
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Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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Continued from page 183

Comment

The smoking continuum presented in this report clearly indicates that the vast majority of smokers in Wisconsin have quit, are actively trying to quit, or are interested in quitting smoking. Of the 850,000 current smokers in this state, 750,000 (87%) would like to quit and more than 300,000 (35%) actually quit for a day or more during the past year. This demonstrates a tremendous opportunity for physicians to intervene and assist smokers in their attempts to quit smoking. It also demonstrates the need for smoking policies, such as smoke-free workplaces, that provide further motivation and support for smokers trying to quit.

Most attempts to quit are unsuccessful and multiple attempts with varying periods of abstinence are common.[2] Persons who do successfully quit smoking have been shown to differ from current smokers on important demographic variables that may have an effect on their ability to quit smoking. For example, older persons are less likely to smoke and are more likely to be trying to quit. These data suggest that younger smokers may move along the continuum from not wanting to quit, to attempting to quit, to successfully quitting as they grow older.

Education appears to be an important factor influencing smoking status. A previous study of smoking and education in Wisconsin found a higher quit ratio (former smokers: ever smokers) for individuals with more than a high school education compared with individuals with a high school education or less.[3] Our study suggests, however, a high rate of interest in quitting–69% of current smokers with a high school education or less have tried to quit smoking.

The public health implications of this study are that most smokers, regardless of age, race, sex, or education, are inter-

Continued on next page

Table 2.–Attempts to quit smoking among current smokers in Wisconsin, 1990.

	Percent current smokers	Proportion who ever tried to quit
Total population	24%	17/24 = 71%
Age		
< 34	28%	17/28 = 61%
35-54	27%	20/27 = 74%
> 55	14%	12/14 = 86%
Gender		
male	24%	18/24 = 75%
female	22%	15/22 = 68%
Race		
white	23%	16/23 = 70%
non-white	33%	28/33 = 85%
Education		
≤ 12 years	29%	20/29 = 69%
> 12 years	18%	13/18 = 72%

ested in or actively trying to quit smoking. These smokers should be supported in their attempts to quit through programs in the health care setting, at work, and in the community. Efforts should involve not only making cessation resources available to these individuals, but should also use cessation materials targeted specially at high risk groups, such as the young and those with less education.

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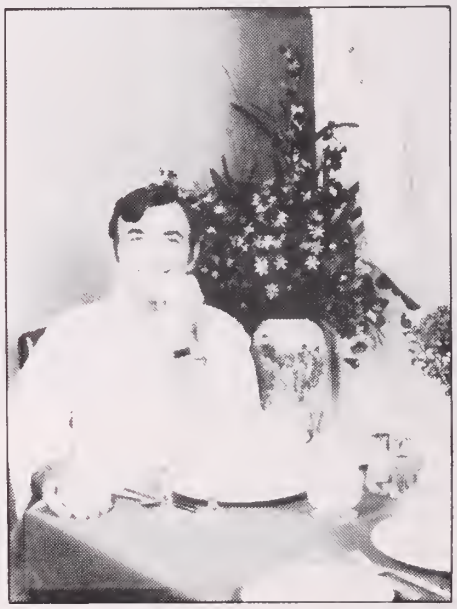

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Angel on snowshoes: Kate Pelham Newcomb, MD, 1886-1956

LeeAnn Kahlor, Milwaukee

Pennies may not fall from heaven, but in the spring of 1954 they showered northern Wisconsin to the tune of over $100,000.

When Kate Pelham Newcomb was featured on the popular television show, "This Is Your Life," she took that opportunity to appeal to millions of viewers across the nation. She told them about the dire need for a hospital in northern Wisconsin's Arbor Vitae-Woodruff area. She also described how community residents there had embarked on a "million dollar penny drive," raising enough money to begin the hospital, but not enough to finish it.

The nation responded and the results were amazing: an avalanche of pennies flooded the post office, enough to finally finish and fully equip the Lakeland Memorial Hospital (now the Howard Young Medical Center) of Woodruff.

Surprisingly, Kate Newcomb's career wasn't sales or public relations, it was medicine, and she was known to the locals of northern Wisconsin as Dr Kate, the "Angel on Snowshoes."

Kate Newcomb grew up during a time when women in the work force were considered unfashionable, yet this never destroyed her dream of pursuing medicine. High mortality rates, and the fact that she had lost many loved ones early in her life, pushed her to try to achieve her dream, despite the odds and pressures by the men in her life to abandon her pursuit for the conventional life of a homemaker and turn-of-the century woman.

Her father, a successful businessman, twice widowed, wanted his daughter to stay at home and care for his large estate. He initially allowed her a career in teaching but would not allow her to pursue medicine. She became a school teacher.

After years of living a life which was stifling and undeniably disagreeable to her, she finally convinced her father to put her through medical school at the University of Buffalo. She graduated cum laude in 1917.

Dr Newcomb obtained her first internship at the New York Infirmary for Women and Children in the lower East Side of Manhattan. Her brief work there took her out at all hours of the night to perform home deliveries in the homes of non-English speaking Italian and Armenian immigrants. After that internship, she entered into another in Detroit, where she eventually took up private practice with two other female physicians. It was also there that she met her husband, Bill Newcomb. The couple remained there and her practice flourished until her husband fell ill with an acute pulmonary condition.

The Newcombs pulled up their Detroit roots and moved to northern Wisconsin in search of fresh air and cleaner surroundings. They settled near the small community of Boulder Junction, 11 miles outside of Woodruff. At this time, Dr Newcomb decided to quit practicing, tend to her husband, and start a family. When her first baby died at 2 days old–from the drugs she had been given during delivery--Dr Newcomb became disillusioned with the state of then modern medicine.

The couple had other children and

Continued on next page

Wanted: unforgettable characters

As part of the introspection and reflection that comes naturally to an organization turning 150 years old, the *Wisconsin Medical Journal* would like to feature the colorful, the admirable, and the unforgettable physicians of Wisconsin. If you know of a physician who you think may merit being featured in the *WMJ*, drop us a line telling us who and why. Or, if you prefer, write the story yourself and submit it for consideration. We can't promise to feature everyone suggested, but we'll strive for a good sampling. Write to: "Historical Profiles" *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.[150th]

lived quietly in their northwoods cabin until a 1931 blizzard forced a local doctor to telephone Dr Newcomb with a plea for help. The physician explained that the life of a woman in a nearby home was in peril; the woman was bound to perish without medical attention. The roads were impassible, and Dr Newcomb was the woman's only chance.

Only then did Dr Newcomb realize how little help was available to the sick in that region. Bag in hand, she began making regular calls on the ill. Undaunted by waist-deep snowdrifts, frozen lakes, and heavily rutted roads, she traveled by snowshoes in the dead of winter or by boat in the summer. A red rag tied to a tree by the side of the road was a signal that the doctor was needed. In a very short time, she became an integral part of the isolated community.

Because of the stressed financial times, it wasn't unusual for "Dr Kate" to decline cash payments from her patients. Most often her compensation took the form of livestock, vegetables, or cords of wood. Having regained his health, her husband supplemented her meager income by guiding tourists through the scenic wilderness.

It was during this tenuous phase of her career that Dr Newcomb cultivated her dream. She looked closely at the resources of the isolated northern Wisconsin region and saw a need for the area to have a health care facility of its own. Without adequate access during the rough seasons, it was vital for residents of these growing communities to access a hospital less than 5 hours away.

The fund-raising events–which facilitated her dream and spurred the penny drive–began in the early 1950s. Construction was planned for the hospital on land donated by a wealthy Chicago businessman, Arthur Rubloff. After saving his wife's life, Dr Newcomb had convinced Rubloff of the community's pressing need for a hospital and he, in turn, initiated the formation of the Lakeland Memorial Hospital Association to raise funds for the project. The idea was to begin construction and spark enough community interest to aid in funding the completion of the project.

By 1952, $50,000 had been collected and building commenced. Dr Newcomb rejoiced: The project was on its way! But after a time, interest waned, contributions tapered off and then one day, construction completely ceased. The project floundered, having lost all momentum.

Then, area high school students devised a plan to raise the necessary funds through the solicitation of pennies–a small but accumulative donation. The project not only took off, it attracted national attention–even in the days before Dr Kate appeared on national TV.

On July 21, 1954, a small hospital in the sparsely populated region of northeastern Wisconsin was dedicated "Lakeland Memorial Hospital." Gov Walter J. Kohler, Jr, proclaimed at the ceremony, "Dr Kate is a genius because she invented something important, not only for her community, but as an example for the country–a hospital of and for the people–and she created it from an idea, a simple idea of service."

Kate Newcomb may not have cured cancer or discovered penicillin, but her selfless role in bringing the medical community and the public together in an effort to assure health care for even the most isolated regions, had much the scope of such accomplishments. The Howard Young Medical Center (renamed after a generous donation by Young in 1972) is now a branch of a larger medical complex called Howard Young Health Care, Inc. The vast rural health care system carries with it the Dr Kate Lakeland Hospice, the Dr Kate Newcomb Convalescent Center, Dr Kate Newcomb Home Health, and Dr Kate's Woodland Manor, along with a number of other facilities.

Kate Newcomb and her dream set the stage for what has become a vital institution to the people of northern Wisconsin. With every new birth, every successful health care treatment, every surgical miracle, the dream lives on.

County society news

Eau Claire-Dunn-Pepin. At the February meeting of the society, Sharon H. Manz, MD; Terence P. Connelly, MD; Craig R. Peterson, MD; and Thomas C. Isaacson, MD, were elected to membership.

Rusk. At the January meeting of the Rusk County Medical society, 16 members were present to hear guest speaker, Bradley C. Hiner, MD, of the Marshfield Clinic, speak on Parkinson's disease and current therapy.

Winnebago. Mary Barham of the SMS Division of Medical Policy and Practice spoke on CPT-4 Evaluation and Management Codes and the Resource Based Relative Value Scale. William Nelson, MD; Rosita Go, MD; and David Yoseloff, MD, were accepted to membership in the society. There were 29 members present at the meeting.

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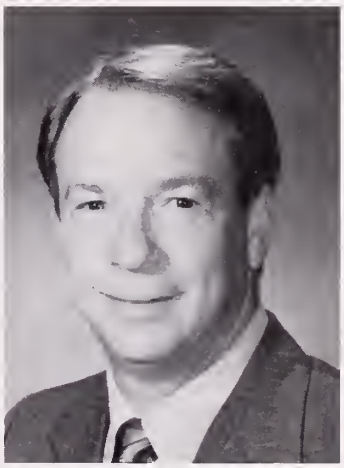
Peter D. Larson



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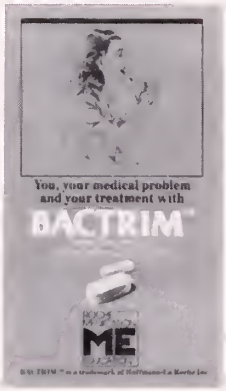

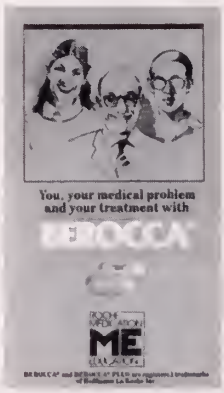

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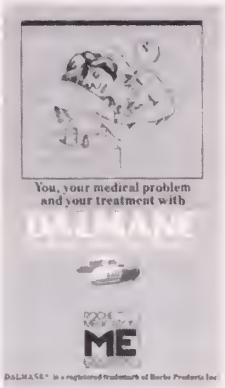

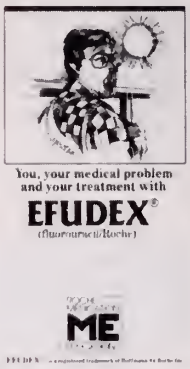

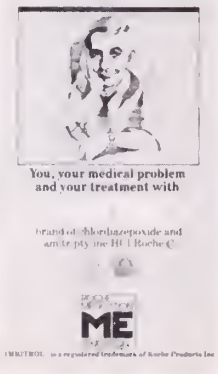

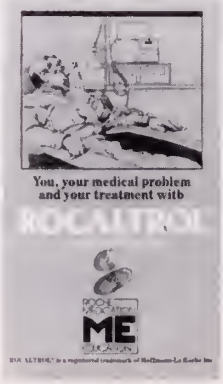

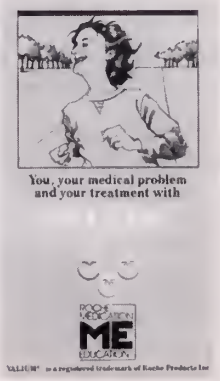

A glimpse into our past

Richard D. Sautter, MD, *medical editor*

15 years ago

What price a life? Six Wisconsin hospitals "entered the world of" CAT scanning, and the technology was hailed by many as the "greatest medical advance in 25 years." They were probably correct. While unnecessary duplication of technology is a problem in some communities, the dollars saved, suffering averted and lives spared by this equipment warrant remembering when every technological advance is immediately labeled as "too costly" by would-be reformers.

Off-setting fouls. The SMS sued the state Department of Health and Social Services, charging that the department illegally instituted a freeze on the level of Medicaid payments to physicians. A Dane County Circuit Court judge ruled in favor of the SMS and issued an injunction preventing the state from continuing the freeze. On the other hand, the SMS asked anyone, anywhere with knowledge or evidence of Medicaid fraud by consumers or providers to contact the SMS for an investigation. That's the sort of involvement and integrity that has made this organization last 150 years, and will likely carry it another 150.

30 years ago

We take it for granted. Closed chest cardiac massage was a "newly developed technique designed to reduce deaths from drowning, electrical shock and other medical emergencies." In an unprecedented program, the Dane County Medical Society trained 175 Madison firefighters and representatives from several statewide organizations in this strange new rescue method. A special demonstration was held at the SMS annual meeting, and the SMS Charitable, Educational and Scientific Foundation sponsored training sessions throughout the state.

The cost of medicine. Answering public charges that medical costs were too high, one physician wrote an article in which he noted: "To make a physician of a high school graduate requires a superior person, eight years time, and $18,000 to $20,000 cash." Well, I don't know in what sense we may be "superior," but I do know that the costs of entering the profession have risen considerably. The specialization required by today's greater and more complex body of medical knowledge has extended the training time, and the cost of medical school tuition alone–nevermind books, supplies, living expenses and undergraduate tuition–now averages $10,000 per year. It is not uncommon for a young doctor to emerge from medical school carrying a debt of $80,000 to $100,000.

Continued on next page

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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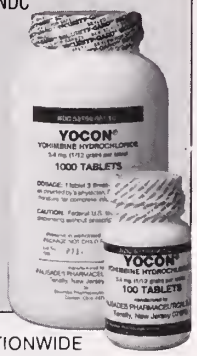

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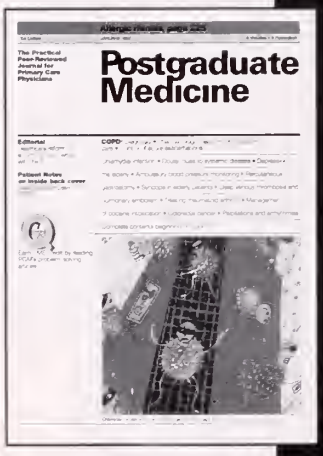

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Postgraduate Medicine

Continued from preceding page

60 years ago

Is this an echo? The SMS House of Delegates created a committee to study the delivery of medical services in Wisconsin with the intent of creating a plan to "make available to all the people everywhere all that is best in medical service at a price commensurate with the ability of the patient to pay." The problem sounds familiar.

A sign of even harder times. In response to the effects of the Great Depression, the SMS published and distributed to its members a pamphlet summarizing Wisconsin's Poor Relief Laws, with an emphasis on how these laws related to physicians. In response to member inquiries, another 1,000 copies were printed and distributed to public officials, particularly county supervisors, who were charged with enforcing laws with which they were unfamiliar.

As a small boy during this era, I remember receiving medical care from the town physician without charge. I also remember that he never cut his own lawn, made firewood, pruned shrubs or, planted a garden, as all these things were done for him. I also remember he must have had more chickens than he or his family could possibly eat. He was the most beloved person in this small community. His kindness was never forgotten.

120 years ago

So what else is new? Best-selling books, talk show guests, and critics of our schools have been telling us for the past few years that we're culturally illiterate, as if this is a new problem they've just uncovered. The chair of the SMS Committee on Medical Education, however, delivered a paper 120 years ago titled "A Higher Standard of Literary Attainment and a Broader Culture, Necessary to Young Men Who Propose to Enter the Profession."

Surgical advances. One of the methods hailed as a great advance in surgery of the time was the use of Professor Esmarch's method, to which "must be ascribed the pleasing honor of a bloodless operation." A rubber bandage was applied to the limb in question, forcing the blood out of it, and a rubber "rope" was applied above as a tourniquet. "A limb can be amputated without the loss of a teaspoon of blood," wrote one author. "No hindrances, no dabbing of sponges into the wound, no blood to obscure the vision of the surgeon... (and) no loss of blood to the patient...."[15pp]

Physician briefs

Bruce A. Kraus, MD,* a Columbus and Rio physician, was recently appointed to the Wisconsin Rural Leadership Program. Over a 2-year period, starting July 1992, Dr Kraus will participate in eight 3-day seminars in Wisconsin, a 1-week national seminar in Washington, DC, and a 2-week international seminar. Dr Kraus serves on the SMS Committee on Aging, Extended Care Facilities and Home Health Care and the Physicians Alliance. He is a past president of the Wisconsin Medical Directors Association and is currently medical director of the Columbia County Home and the Columbus Care Center.

Paul Carbone, MD,* Madison, has been elected medical director-at-large of the American Cancer Society Wisconsin Division board of directors. Dr Carbone specializes in oncology and is the director of the Wisconsin Clinical Cancer Center.

Donald Romsa, MD, recently accepted an award from President George Bush on behalf of all those affiliated with the Health Care Network, Inc, of Racine. The group, made up of seven volunteer doctors, eight nurses and other who provide free or low-cost health care to low-income uninsured Racine residents, was selected as the 720th Point of Light in Bush's 1,000 Points of Light Campaign.

Victor Falk, MD,* David Gattuso, MD,* Nalini Madan, MD,* Suresh Madan, MD,* Thomas Shearer, MD,* and **William West, MD,*** all Edgerton area physicians, have formed one clinic to improve patient care and convenience. The new group, Affiliated Physicians, will be affiliated with University Hospital in Madison and Edgerton Memorial Community Hospital. Offices will be in Edgerton and Milton.

Mark Olsky, MD, of Monroe, has been named director of emergency medicine at St Clare Hospital in Monroe. A fellow of the American College of Emergency Physicians, Dr Olsky has served on the boards of directors for state emergency medicine associations in both Illinois and Wisconsin. He is a graduate of the Northwestern University medical school. He served an internship at Northwestern-Evanston Hospital and a residency at the University of Michigan. Dr Olsky is board certified in internal medicine and emergency medicine.

Francis Kaveggia, MD,* an urologist, has joined the staff of the Janesville Medical center. He earned his medical degree from the University of Wisconsin School of Medicine and completed a urology internship at Gunderson Clinic in La Crosse. Dr Kaveggia served a residency at the University of Nebraska Medical Center in Omaha.

Richard R. Heckert, MD,* an ophthalmologist, has joined the staff of Green Bay Eye Clinic. Dr Heckert completed his fellowship training in ophthalmology and strabismus at the University of Iowa Hospitals and Clinics.[150th]

Obituaries

Edwin O. Niver, MD, 86, formerly of Eau Claire, died Nov 6, 1991, in Pepper Pike, Ohio. Dr Niver was born May 17, 1905, in Cleveland, graduated from Western Reserve University School of Medicine, and served his internship at Charity Hospital in Cleveland. His psychiatry residency was completed at Galveston State Psychopathic Hospital in Texas. Dr Niver served in the US Army from 1941 to 1946. He retired from medical practice in 1971. He was a member of the Eau Claire-Dunn-Pepin County Medical Society, the SMS, and the AMA.

Joseph R. Matt, MD, 73, of Oconomowoc, died Dec 11, 1991, in Oconomowoc. He was born March 31, 1918, in Milwaukee, and graduated from Marquette University School of Medicine. His internship was served at St Joseph Hospital, in Milwaukee, and his residency completed at St Joseph Hospital in Parkersburg, WVa. Dr Matt served on the medical staff of the Wilkinson Clinic in Oconomowoc, and in the US Army from 1944 to 1946. He was a former chief of staff at Oconomowoc Hospital. Surviving are his widow, Patricia; three sons, Joseph, James, and Fred; and two daughters, Patricia Yakish and Anne.

Arno H. Fromm, MD, 89, of Madison, died Dec 23, 1991, in Madison. Dr Fromm was born on May 6, 1902, in Elkhart Lake, and graduated from Marquette University School of Medicine. His internship was served at St Mary's Hospital in Milwaukee. Dr Fromm did post-graduate work in New York, Minnesota, and Illinois. He held teaching positions at the University of Wisconsin and Marquette medical schools. Dr Fromm retired from his medical practice in 1988. Surviving are his widow, Constance, and two daughters, Barbara Kuk, of Elmhurst, Ill, and Kathleen Lane, of Los Angeles.

Continued on next page

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Arthur C. Hansen, MD, 89, of Wauwatosa, died Dec 16, 1991, in Milwaukee. Dr Hansen was born Oct 8, 1902, in Racine, and graduated from the University of Wisconsin Medical School. His internship and residency were completed at Milwaukee County General Hospital. Dr Hansen was the medical director of the A.O. Smith Company from 1941 until his retirement in 1967. He also had been in private practice. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Sophie, and a daughter, Suzanne Carol Hansen.

John A. Knights, MD, 80, of San Jose, Calif, formerly of Superior, died Nov 30, 1991 in San Jose. Born Dec 16, 1911, in Crookston, Minn, Dr Knights graduated from George Washington Medical School in Washington, DC. He served his internship and residency at the Receiving Hospital in Detroit. He was the radiologist at Superior Memorial Hospital until his retirement in 1982. He had been a member of the Douglas County Medical Society, the SMS, and the AMA. Surviving are two daughters, Sue Ellen Geiger, of San Jose, and Barbara Porter, of North Franklin, Conn.

Harry B. Sadoff, MD, 89, of Fox Point, died Dec 17, 1991, in Fox Point. Dr Sadoff was born in Russia, and graduated from Marquette University School of Medicine. He served his internship at the Milwaukee Evangelical Deaconess Hospital. His residency in orthopedic surgery was completed at the Hospital for Joint Diseases in New York City. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Ann; and two sons, Armin, of Los Angeles, and Ronald, of Glendale.

William E. Braun, MD, 72, of Merrill, died Dec 9, 1991, in Merrill. Dr Braun was born June 15, 1919, in Ashland, and graduated from Marquette University School of Medicine. His internship was completed at the US Naval Hospital in San Diego and his residency in orthopaedics surgery at Wood VA Hospital in Milwaukee. Dr Braun headed the orthpedic department at the VA Hospital in Iron Mountain, Mich. He had his medical practice in Kenosha for more than 2 years and in 1954 returned to the Merrill area practicing orthopaedics until his retirement in 1981. He was a member of the Lincoln County Medical Society, the SMS, and the AMA. Surviving are his widow, Naomi; one daughter, Sandra Lynn, of Seattle; and four sons, Daniel, of Minneapolis; Gary, of Edina; Peter, of Wausau; and William, of Madison.

Nathan E. Bear, MD, 88, Fayetteville, Ark, formerly of Monroe, died Jan 9, 1992, in Fayetteville. Dr Bear was born Oct 15, 1903, in Monroe, and graduated from Northwestern University Medical School. His internship and residency were completed at Augustana Hospital in Chicago. Dr Bear served in the US Navy from 1942 to 1936. He was the last surviving founder of The Monroe Clinic which was founded in 1939. Dr Bear retired in 1979 and moved to Fayetteville in 1986. He was a member of the Wisconsin Surgical Society, the Green County Medical Society, the SMS, and the AMA. Surviving is his widow, Ellen, of Fayetteville, Ark.

Alvin L. Berman, PhD, 67, of Madison, died Dec 2, 1991, in Madison. Dr Berman was professor emeritus in the Department of Neurophysiology at the University of Wisconsin Medical School and the Waisman Center in Madison. He was the first scientist to be elected to the status of scientific fellow of the State Medical Society. He received his PhD in neurophysiology from Johns Hopkins University, and had been involved in research and teaching in neuroanatomy at the University of Wisconsin in Madison. Surviving are his widow, Gloria; three children, Jean Martens, of Lombard, Ill, Marjorie, of Philadelphia, and Tom, of Madison.

Frederick H. Goetsch, MD, 64, of Spooner, died Feb 27, 1992, in Spooner. Dr Goetsch was born Sept 13, 1927, in Watertown, and graduated from the University of Wisconsin Medical School in Madison. He served an internship at St Luke's Hospital in Duluth, Minn. Dr Goetsch practiced in Spooner at Community Memorial Hospital and Clinic from 1954 to 1992. He was a diplomate of the American Academy of Family Physicians, a member of the Barron-Washburn-Burnett County Medical Society, the SMS, and the AMA. His wife, Beth, preceded in him death in September 1991.

Frank N. Pansch, MD, 81, of Madeira Beach, Fla, died Jan 18, 1992, in Madeira Beach. Dr Pansch was born May 2, 1910, in Oshkosh, and graduated from Northwestern University Medical School. His internship was served at Ancker Hospital, St Paul, and his residency completed at the Mayo Clinic in Rochester. Dr Pansch served in the US Navy from 1943 to 1946. He was a member of the American Society of Abdominal Surgeons, the American Association of OB/GYN, the International College of Surgeons, the Winnebago County Medical Society, the "Fifty Year Club" of SMS, and the AMA. Dr Pansch was married and had four children.

John T. Schmitz, MD, 71, of Milwaukee, died Jan 14, 1992, in Oak Creek. Dr Schmitz was born May 2, 1920, in Sparta, and graduated from Marquette University School of Medicine. His internship was served at Columbia Hospital and his residency in OB/GYN completed at St Mary's Hospital in Milwaukee. Dr Schmidt served in the US Army from 1946 to 1948. He retired from practice in 1990. Active in SMS affairs he had been a member of the Committee on Environmental and Occupational Health for a number of years. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Lois; three sons, John, Theodore, and Dr Gerard; three daughters, Marynell Lubinski, Suzanne and Kathleen Schmitz, and step-father of Cindy Schaefer-Padilla, Dr Karen Schaefer, Mary Ann Schaefer, Janet Wood, and Teresa Schaefer-Erickson.

Charles E. Shearer, MD, 70, of Milton, died Jan 8, 1992, in Edgerton. Dr Shearer was born Feb 3, 1921, in Edgerton, and graduated from the University of Louisville School of Medicine. After completing his internship at Augustana Hospital in

Chicago, Dr Shearer served in the US Army from 1946 to 1948. He completed his general surgery residency at the Ochsner Clinic in New Orleans. Dr Shearer practiced in Columbus from 1954 to 1970. He joined his brother, Dr Thomas Shearer, at the Shearer Cohen Clinic and at the Edgerton Memorial Community Hospital from 1970 to 1980. He retired from medical practice in 1980 and served as medical consultant for the Social Security Disability Board in Madison until shortly before his death. Dr Shearer was a member of the Wisconsin Surgical Society, the Rock County Medical Society, the SMS, and the AMA. Surviving are his widow, Jean; two sons, Douglas, of Marquette, Mich, and Charles, of Oak Park, Ill; two daughters, Mary Winegar, of Salt Lake City, Utah, and Joan Maybery, of Ogden, Utah; and a step-son, Anthony Frey, of Madison.

Donald A. Smith, MD, 65, of Fond du Lac, died Jan 18, 1992, in Madison. Dr Smith was born July 21, 1926, in Chippewa Falls, and graduated from the University of Wisocnsin Medical School in Madison. His residency in orthopedic surgery was completed at the Cleveland Clinic and at University Hospital and Clinics in Madison. He served in the US Navy during world War II. Dr Smith retired from his practice in Fond du Lac in 1991. He was a member of the American Academy of Orthopedic Surgeons, the Fond du Lac County Medical Society, the SMS, and the AMA. Surviving are his widow, Jean; two sons, Dr William, of Rice Lake, and Gregory, of Fond du Lac; one daughter, Barbara, of Milwaukee, and two grandchildren.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.

William E. Marquis, MD, 77, of Waunakee, died Feb 11, 1992, in Waunakee. Dr Marquis was born Aug 28, 1914, in Wausaukee, and graduated from Marquette University School of Medicine. He had his medical practice in Waunakee until his retirement in 1986. Surviving are his widow, Alice; four daughters, Jeanne, of Dane, Marianne Schlecht, of Mount Horeb, Denise Johnson, of Sheboygan Falls, Mimi Wagner, of Mazomanie; and two sons, Dr Arthur, of Watertown, and Dr William, of Grand Rapids, Michigan,

Wimal J. Yapa, MD, 55, of Oshkosh, died Feb 20, 1992, in Oshkosh. Dr Yapa was born Feb 18, 1937, in Colombo, and graduated from the University of Sri Lanka Colombo Faculty of Medicine. He was director of adult services and acting clinical director at Winnebago Mental Health Institute. Dr Yapa studied in England and was board certified in psychiatry. Surviving are his widow, Soma; a daughter, Chelika, of Irvine, Calif, and a son, Dr Jeevaka Yapa, of Chicago.

Russell H. Owen, MD, 70, of Milwaukee, died Feb 29, 1992, in Milwaukee. Dr Owen was born Sept 25, 1921, in Dunn County, and graduated from the University of Wisconsin Medical School, Madison. His internship was served at St Mary's Hospital in Madison, and his anesthesiology residency completed in Madison and Monroe. Dr Owen had a private practice in Madison for several years before moving to Milwaukee. He retired as aassistant professor anesthesiology at the Medical College of Wisconsin in 1987. Surviving are two sons, John and James; and a daughter, Dianne Bowman.

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American Heart Association

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William Hocking, MD, wins the 1992 *WMJ* photo contest

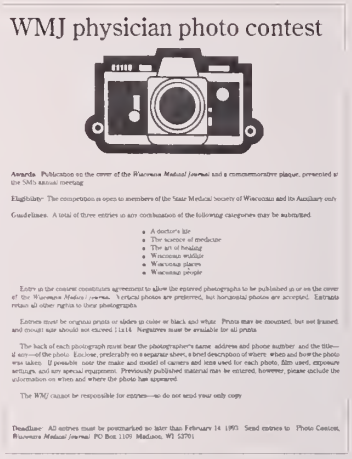
The cover photo for this edition of the *WMJ*, "Sunrise on Bearskin Lake," is the winner of the *WMJ* physician photo contest for 1992. The photographer is William G. Hocking, MD, of Marshfield.

Four honorable mention award winners were also selected: "Devil's Lake," by Al Fisher, MD, of La Crosse; an untitled black and white Wisconsin landscape by Hans P. Anderson, MD, of La Crosse; an untitled color photo of Canada geese on a sunlit golden pond, by A.M. Richter, MD, of Waukesha; and "Bearskin Lake in Fall," also by William Hocking, MD.

Forty-six photos were entered in the contest as a whole, but three of the six categories had no entries and one of the remaining three had only one entry. The categories were, therefore, eliminated, and an overall winner was named.

The *WMJ* expresses its gratitude to Bill Fritsch, of the Harper-Fritsch Studios in Madison, for lending his expertise to the panel of judges.

Entries for the 1993 competition are now being accepted. Please see page 168 for the complete guidelines. 150th



WMJ physician photo contest

Awards: Publication on the cover of the *Wisconsin Medical Journal* and a commemorative plaque, presented at the SMS annual meeting

Eligibility: The competition is open to members of the State Medical Society of Wisconsin and its Auxiliary only

Guidelines: A total of three entries in any combination of the following categories may be submitted:

- A doctor's life
- The science of medicine
- The art of healing
- Wisconsin wildlife
- Wisconsin places
- Wisconsin people

Entry in the course constitutes agreement to allow the entered photographs to be published in or on the cover of the *Wisconsin Medical Journal*. Vertical photos are preferred, but horizontal photos are accepted. Entrants retain all other rights to their photographs.

Entries must be original prints or slides in color or black and white. Prints may be mounted, but not framed, and mount size should not exceed 11x14. Negatives must be available for all prints.

The back of each photograph must bear the photographer's name, address and phone number, and the title—if any—of the photo. Enclose, preferably on a separate sheet, a brief description of where, when and how the photo was taken. If possible, note the make and model of camera and lens used for each photo, film used, exposure settings, and any special equipment. Previously published material may be entered, however, please include the information on when and where the photo has appeared.

The *WMJ* cannot be responsible for entries—so do not send your only copy.

Deadline: All entries must be postmarked no later than February 14, 1993. Send entries to: Photo Contest, *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.

Honorable mention: Untitled by Hans P. Anderson, MD, of La Crosse.

Honorable mention: Untitled by A.M. Richter, MD, of Waukesha.

Honorable mention: "Bearskin Lake in Fall," by William Hocking, MD, of Marshfield.

Honorable mention: "Devil's Lake," by Al Fisher, MD, of La Crosse.

CES Foundation donors

THE PERSONS and organzations named below made contributions to the Charitable, Educational and Scientific Foundation during January and February 1992.

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In recognition of those individuals, county medical societies and auxiliaries who contribute their support to the Fort Crawford Medical Museum.
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Dr and Mrs Robert Schmidt
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SMS

In Memoriam
In loving memory of those individuals who will grace our paths forever.
Richard W. Adams
David J. Ansfield, MD
Alvin L. Berman, MD
Leo M. Boxer, MD
William E. Braun, MD
William Campbell
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SMS membership contributions
The persons and organizations named below made contributions to the Charitable, Educational and Scientific Foundation through the SMS membership dues statement from Dec 1, 1991, through Jan 31, 1992.

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Limited call. Immediate need exists for a family physician to join a well established primary care practice located 1/2 hour from metro area of 250,000 with NFL football franchise, major academic universities and abundant recreational facilities. This 12 physician group enjoys quality of life with a call schedule of only three days per month. Large clinic site has abundant exam rooms, complete radiology, full computerization and in-house pharmacy. The community is equally attractive with 40 miles of residential shoreline, quality schools, and numerous golf courses nearby. We seek a warm, friendly physician who enjoys obstetrics, a 4 1/2 day work week and good compensation. For complete information, send your CV to Tom Hart, of Harris Kovacs Alderman, 5420 Southern Ave, Suite 407, Indianapolis, IN 46241, or call him at 800-776-7901, ext #2-042. 4/92

Family practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or set-up his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr Paul Hayes' offices 906-563-9255 or Dr William Gladstone's home 906-563-8743. Anderson Memorial Hospital, Main Street, Norway, Michigan 49870, 906-563-9243. 4/92

Oshkosh, Wisconsin. Single specialty groups are recruiting in orthopedic surgery, ophthalmology, child psychiatry, OB/GYN, and cardiology. Oshkosh is an attractive community of 55,000 (service area of 85,000) people located on the shores of Lake Winnebago and in the heart of Wisconsin's beautiful Fox River Valley. Competitive financial packages. Contact Christopher Kashnig, physician recruiter, Mercy Medical Center, 631 Hazel Street, Oshkosh, WI 54902; or call 800-242-5650 x2430 or 414-236-2430. 4-6/92

Ideal internal medicine practice. Excellent opportunity for BC/BE internist to establish a prosperous practice. Progressive 107-bed community hospital with a medical staff of 45 physicians and a service area population of over 45,000. Vibrant northern Michigan community with all summer and winter recreational activities. Salary guarantee of $110,000 with excellent benefits. Send CV or contact: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801, 800-323-8856. 4/92

BE/BC emergency medicine physician to join four other board certified ER physicians independently contracted at a 126-bed hospital in central Wisconsin. The ED is a mixture of level II and III. There were 12,840 ER visits last year. Twelve and 24-hour shifts, working 36 to a 48 hour work week. This hospital is located in a bedroom community of 50,000 people and is 20 minutes away from a major university setting. Excellent recreational four season community. Minutes from one of the finest golf courses in the midwest. Prime location to raise a family in a safe environment. Guaranteed income well into the six figures plus comprehensive benefit package. To learn more please contact Bret Lepper at 1-800-236-0488. 3-4/92

Urgent care. FT or PT opportunities available in busy, well established Cedar Rapids urgent care center. Occupational medicine including pre-employment evaluations and work-related injury treatment also are part of the practice. X-ray, laboratory, and physical therapy services available within clinic. Cedar Rapids, population 110,000 is located in eastern Iowa and is 30 minutes from the University of Iowa. Excellent compensation and scheduled hours. Mail CV or call Bob Waste, Mercy Care Management, PO box 786, Cedar Rapids, Iowa 52406; ph 319-398-6460. 4-6/92

Wisconsin. Fourth BC/BE obstetrician/gynecologist needed to join stable, progressive, primary-care based HMO/group practice in University town of 60,000 near Minneapolis/St Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact Stuart R. Lancer, MD, MBA, Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702; 715-836-8552. 4-6/92

Physician-medical director. Full time for urgent care center. Eventual partnership possible. Send resume to: Joan M. Gennrich, MD, 10804 W. Capitol Dr, Wauwatosa, WI 53222; FAX 414-466-2855. 4/92

Fellowship offered in addictionology for physicians interested in diagnosis and treatment of alcohol and drug abuse problems. Fellow will be involved in all aspects of alcohol and clinical dependency rehabilitation to include: **1)primary patient evaluation; 2)diagnosis; 3)treatment protocols; 4)daily rounds; 5)counseling; 6)psychiatric evaluation; 7)group therapy; 8)staffing; 9)seminars.** Stipend, $27,000, plus malpractice insurance and fringes. Interested candidates please contact Mona Owens Beck, De Paul Hospital, 4143 S. 13th St, Milwaukee, WI 53221; ph 414-281-4400, ext 565. 4-5/92

Family practice physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD,MBA, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 4-6/92

Door County, Wisconsin. BC/BE internist. Modern, 89-bed community hospital with new outpatient services addition. Competitive

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Milwaukee area. A rapidly expanding 60-physician multi-specialty clinic, seeks BC/BE physicians in the following specialties: internal medicine, family practice, orthopedic surgery, ob/gyn, urology, dermatology, and psychiatry. Competitive salary, excellent fringe benefits. Address inquiries and CV to: Administrator, PO Box 427, Menomonee Falls, WI 53052-0427. 3-5/92

Urgent care. Busy department in 60 member multi-specialty clinic to add urgent care physician immediately. Excellent salary and benefits. Beautiful southern Wisconsin. Send CV to Dr Stan Gruhn, Riverview Clinic, 580 N. Washington St, Janesville, WI 53545. 12/91;1-5/92

Medical Director. Great Lakes! Direct your attention this way! New position with prestigious 40-member multi-specialty group of top income earners. Full-time, non-clinical opportunity. Physician advocate. Liaison to all parties. MD candidates should have experience and/or related graduate education. Highly competitive compensation package. A good attitude about medicine and a sense of humor preferred. Modern clinic located in mid-sized community on Lake Michigan between Milwaukee and Chicago. Rebecca Turley, Vice President, Fox Hill Associates, 250 Regency Court, Milwaukee, Wisconsin. Ph 1-800-338-7107; Fax 1-414-785-0895. 3-4/92

Door County, Wisconsin. Emergency medicine. BC/BE family practice, internal medicine, pediatrics, or emergency medicine. General emergency medicine experience required. ACLS/ATLS required. PALS preferred. Full-time position with 8-10 24-hour shifts monthly with flexibility. Competitive salary and benefits package. Modern 89-bed hospital with a new emergency department and outpatient services addition. Approximately 10,000 visits per year. Exceptional four seasons recreation along Lake Michigan shores. Proximity to Milwaukee/Chicago. Top rated schools. Quality community life. Send CV to Priscilla Khoury, Physician Recruitment Coordinator, 330 South 16th Place, Sturgeon Bay, WI 54235. 3-5/92

Occupational medicine physician. The Medical-Surgical Clinic, SC, a multi-specialty clinic in Milwaukee, Wis, with an Occupational Medicine Department that has been a leader in providing quality occupational medicine for almost 50 years and offers a full range of occupational medicine services, seeks to add another physician that is either a BC/BE or experienced in occupational medicine or a BC/BE internist or family practice physician with occupational medicine experience. Competitive salary and fringe benefit package, including a profit sharing plan. Send CV to Thomas F. Bremer, Administrator, The Medical-Surgical Clinic, SC, 2400 West Lincoln Ave, Milwaukee, WI 53215. 3-4/92

UNIVERSITY OF MINNESOTA MEDICAL DIRECTOR POSITION

Boynton Health Service, a large multi-specialty outpatient facility affiliated with University of Minnesota Hospital and Clinic, is seeking a medical director. This position is responsible for coordinating and supervising all medical services to 50,000 students, faculty, and staff.

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Position available July 1, 1992 or sooner. Please send resume and three names of references by May 15, 1992 to: **Boynton Health Services, Attn: Michael Coomes, MD, Chair, Search Committee, 410 Church Street SE, Minneapolis, MN 55455; ph 612-624-2933.** The University of Minnesota is an equal opportunity educator and employer. 4/92

Seeking BC/BE general internist to work in established internists office in West Allis. Flexible hours, possible long term affiliation. Hospital and office practice. Guaranteed compensation plus incentive option. Please contact Barton-Collins Ltd, 9401 West Beloit Rd, Suite 312, Milwaukee, WI 53227; ph 414-541-6099. 3-4/92

University of Wisconsin Hospital and Clinics is recruiting physicians interested in staffing Med Flight, its hospital-based helicopter critical care transport program. Board eligible/certified physicians (*eg* emergency medicine, internal medicine, family practice, general surgery). ACLS/ATLS certification preferred. Compensation $40/hour for in-house, on call; duties limited to Med Flight adult care (pediatric neonatal and high risk obstetric cases excluded). Academic clinical appointment commensurate with experience, training and board certification. Send resume to: H. Michael Bowman, MD, Emergency Medicine, C5/345 Clinical Science Center, 600 Highland Ave, Madison, WI 53792 by June 1, 1992. Wisconsin has an open records law. University of Wisconsin is an Equal Opportunity/Affirmative Action Employer. p4/92

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Physicians Exchange

Continued

Southeast Wisconsin lakefront community. Urgent care and two family practitioners needed for expanding 37-physician multi-specialty group. Twenty minutes to Milwaukee, one hour to Chicago. Partnership possible within 18 months. Call or write Lee Fivenson, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; ph 1-800-338-7107. 3-4/92

Staff psychiatrist. Medium-size smoke-free environment medical center offers primary and extended care to a large area of west central Wisconsin. Full range of psychiatric services include admissions (acute), geriatric, long-term care, out-patient, PTSD, and alcohol. Salary range to $119,500, depending on qualifications and board certification. Excellent benefits package includes malpractice protection, 30 days paid vacation, and annuity plan. Relocation expenses. 173-acre facility includes limited on-station housing and nine hole golf course. City of 7500 in a predominantly rural area that offers affordable real estate, good schools. Conveniently located on I-90/94 midway between Milwaukee and Minneapolis. Call or write: Eugene J. Traynor, MD, Chief, Psychiatry Service (116A), VA Medical Center, 500 East Veterans St, Tomah, WI 54660; 608-372-1631. EO/AAE. 1-4/92

The Wausau Medical Center is seeking board certified/eligible individuals in the following specialties: dermatology, family medicine, gastroenterology, hematology/oncology, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year-round as well. Write or call collect D. K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401; ph 715-847-3254. c1tfn/91

Minnesota. Private practice opportunities in family medicine. Join established clinics with first year guarantees, benefits, and quality management. **Arlington, Eden Prairie, Hopkins, Montgomery, Monticello, Mound, Morris, Wayzata & Grantsburg, Wisconsin.** Contact: Jerry Hess, LifeSpan Hospitals (16501) 800 East 28th St, Minneapolis, MN 55407; 800-248-4921 or 612-863-4193. 2-4/92

Time for living! Time for family, children, traveling, hobbies, sports, hiking, music, boating, art, skiing, community activity. Madison Ambulatory Care Center, outpatient family practice, occupational health. Approximately 25 hours per week, very flexible scheduling. Salary incentive bonus, plus paid health, life, malpractice, 401K. Contact David Goodman, MD, MedicEast, 2810 East Washington Ave, Madison 53704; ph 608-244-1213. 1tfn/91

SE Wisconsin pediatrics. Join busy pediatric group in prospering community close to Milwaukee, Madison, and Chicago. Rewarding lifestyle, capable colleagues, shared call, first-class hospital with special care nursery. Please contact Kathryn Iorio, MD, Waukesha Pediatric Associates, Ltd, 1111 Delafield St, #115, Waukesha, WI 53188; 414-542-6999. 2-4/92

Family practitioner to join a progressive 13-physician group practice. Rural college town 30 miles from St. Paul, Minnesota, new clinic and constructing new hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. c9tfn/91

Internist to join two internists in active practice in scenic Upper Michigan. Medical school affiliation. Contact North Shore Internal Medicine, 2420 First Ave South, Escanaba, MI 49829; ph 906-786-1563. p11tfn/91

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Medical Meetings-Continuing Medical Education

May 29-30, 1992: 1st Annual Clinical Neurology and Behavioral Sciences Symposium: Focus on Geriatrics, at Landmark Inn Resort, Egg Harbor. Info: Nadine Punke, Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449; ph 1-800-782-8581, ext 5207. 3-5/92

May 30, 1992: Cytokines and Transplantation, 3rd annual Rush symposium on transplantation, at Rush-Presbyterian-St Luke's Medical Center, Chicago, Ill. Fee: $150. To register, call 312-942-6242. 3-5/92

August 5-9, 1992: 43rd Annual Meeting International Doctors in AA (IDAA) in Grant Rapids, Michigan. Registration information: Connie Hyde, 3311 Brookhill Circle, Lexington, KY 40502; ph 606-233-0000; 606-277-9379; 606-253-0864 (FAX). 3-7/92

October 15-18, 1992: 44th Annual AAFP Scientific Assembly in San Diego. Info: AAFP, 8880 Ward Pkwy, Kansas City, MO 64114; ph 816-333-9700; 816-822-0580 (FAX). g3-9/92

November 8-12, 1992: Ninety-Sixth Annual Meeting of the American Academy of Ophthalmology at Dallas Center. Contact: The American Academy of Ophthalmology, Meetings Dept, PO Box 7424, San Francisco, CA 94120-7424; ph 415-561-8500. g3-9/92

AMA

June 21-25, 1992: Annual AMA House of Delegates, Chicago.
December 6-9, 1992: Interim House of Delegates, Nashville.
June 13-17, 1993: Annual AMA House of Delegates, Chicago.

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 55 cents per word, with a minimum charge of $25.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg,* copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association.*

Medical Meetings-Continuing Medical Education

December 5-8, 1993: Interim House of Delegates, New Orleans.
June 12-16, 1994: Annual AMA House of Delegates, Chicago.
December 4-7, 1994: Interim House of Delegates, Honolulu.

Advertisers

Air Force Medicine 180
Ely Lilly & Company 184, 185
Axid®
General Internal Medicine 165
Medical College of Wisconsin
Medical College of Wisconsin 181
Physician Referral Network
Medical Protective Compnay 167
Palisades Pharmaceutical 191
Yocon®
Parke-Davis 177, 178
Accupril®
PBBS Equipment Corp 182
Peppino's 186
Physicians Insurance Company of Wisconsin ..... IFC
Post Graduate Medicine 192
Roche Laboratories 189, 190
Searle Company, G.D. ..... BC
Calan SR®
Sister Bay Resort & Yacht Club 165
SMS Services ..... IBC
Wipfli Ullrich Bertelson CPAs 175

State Medical Society of Wisconsin

Dates and locations of
ANNUAL MEETINGS
1992-1994

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1992 - April 22-25: Milwaukee
1993 - April 15-17: La Crosse Convention Center, Radisson
1994 - April 14-16: Milwaukee

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

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References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus.* New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol.* 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol.* 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation.* 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology.* 1988;39:1025-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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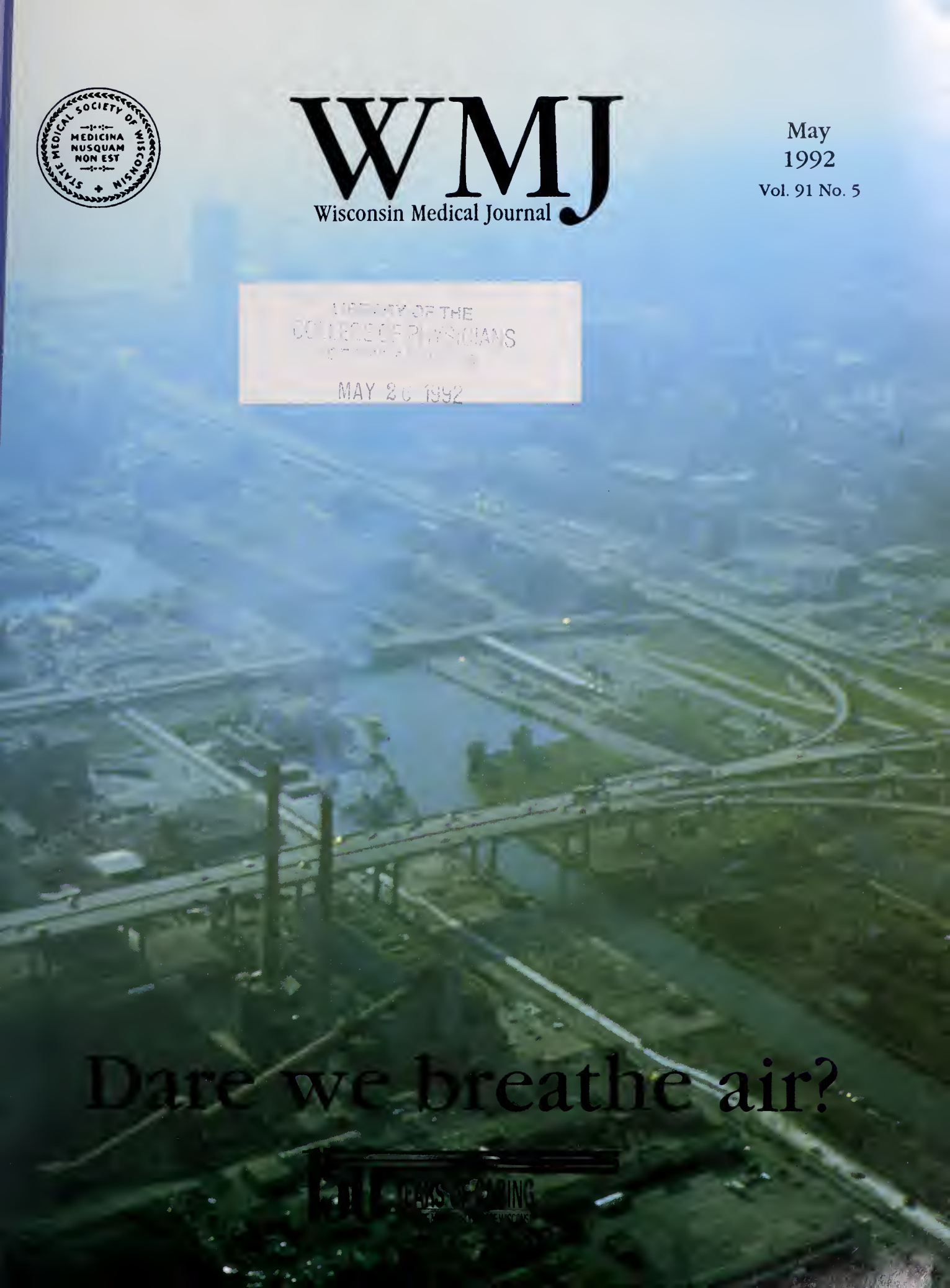

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Contents

May 1992 Vol. 91 No. 5

Opinions

205 *President's page*
Stay the course
by William J. Listwan, MD, West Bend
209 *Secretary's report*
Only the inflexible die young
by Thomas L. Adams, CAE, Madison
210 *Soundings*
Sickday
by Jonathan Temte, MD, Madison
210 *Letters*
A comment on breast reconstruction
by Paul W. Loewenstein, MD, Milwaukee

Scientific

211 Posterior hip dislocation in a rural emergency department
by Dean Stueland, MD, and Ronald R. Rothfusz, MD, Marshfield
214 Acute adrenal insufficiency: hemodynamic and echocardiographic characteristics
by John M. Lawton, MD, Green Bay

Special section

219 Blood-borne pathogens: An overview of OSHA standards and an exposure control plan

Socioeconomic

235 Tube feeding in Wisconsin: medicine and law in conflict
by Richard S. Kane, MD, Milwaukee
240 *Public health*
Ground-level ozone in Wisconsin: potential health effects
by Jay Goldring, PhD, and Robert D. Morris, MD, PhD, Madison and Milwaukee

Organizational

245 The great master of abdominal surgery: Nicholas Senn, MD, 1844-1908
by Shari Hamilton, *assistant editor*
250 A glimpse into our past
by Richard D. Sautter, MD, *medical editor*
251 Physician briefs
251 Photo contest corrections
252 AMA awards
254 Obituaries
254 County society news

Our cover: A polluted Milwaukee skyline. Photo by Jay Goldring, PhD. See related article on page 240.

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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State Medical Society of Wisconsin

Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's page

Stay the course

I AM ACUTELY AWARE, and most of you will also recognize, that this is my first "President's page" in the *Wisconsin Medical Journal.* This is one of the privileges that accompany the many responsibilities that accrue to the president of the State Medical Society of Wisconsin. During the past year, I have been gradually inching my way into the water, but in March of this year I was bodily thrown into the deep water and forced to swim. Preparing this article in time to meet the April 10 press deadline was a reminder to me of the work ahead.

In April 1991, when I became president elect of the SMS, I felt a bit overwhelmed by the responsibility. I calmed myself by saying over and over again, "They must know what they're doing." By they, I meant the membership of the SMS who elected me to the position. I feel more comfortable about the job now that I have spent the last year as Kim Hetsko's understudy. I plan to continue the fine job he has done for all of us.

The transition from Kim to me will be smooth, and, in turn, I will begin the process of helping Pauline Jackson to prepare herself for the presidency of the SMS. I have worked with Pauline before and I know we will have a good working relationship. I will depend on her to help me out a great deal this year. Together we will "stay the course" and make sure the SMS stays on track and remains responsive to your needs.

Before I accepted the nomination as president elect, I gathered information about the office. I reviewed the constitution and bylaws, as well as other written materials about the office of president. I discussed the office and the effect holding it would have on an individual physician with a number of past presidents of our society.

The primary responsibility of the president is to act as the official public spokesperson for the Medical Society. The president represents the Society to its members and to the public at large. The president must be a good speaker and must be well informed on the many different issues that effect medicine and our patients.

William J. Listwan, MD

The result of this is many speaking engagements to county medial societies, attendance at neighboring state medical society meetings, presentation and acceptance of awards on behalf of the SMS, public speaking to non-physician groups, political contacts with the state admini-

Continued on next page

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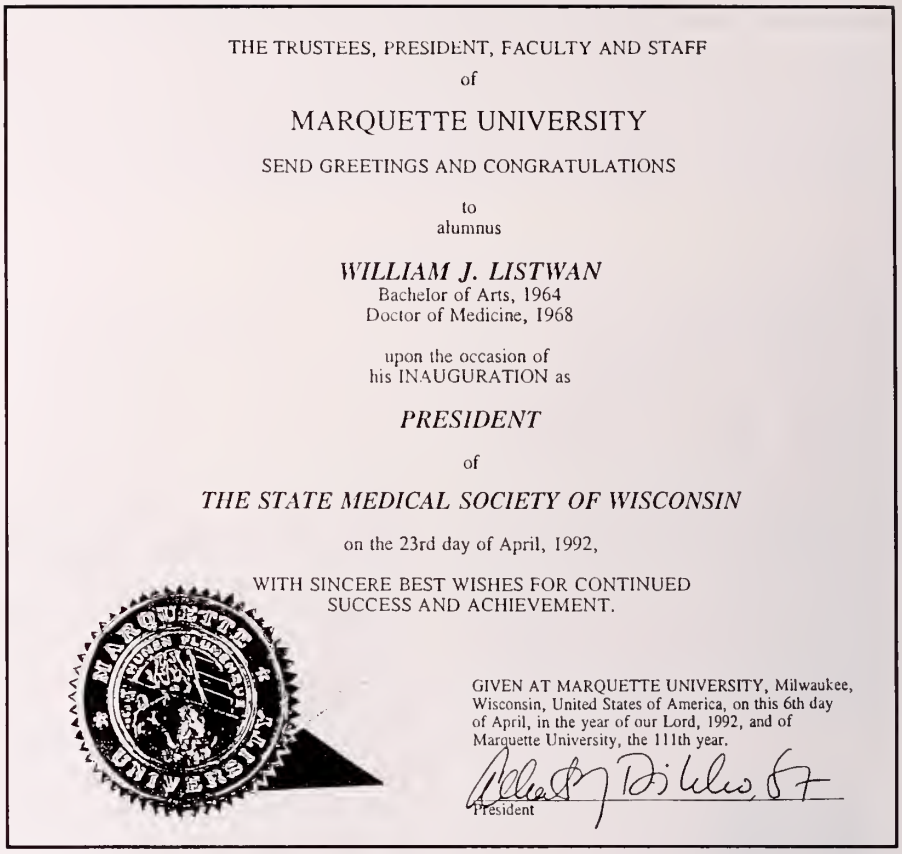
Continued from preceding page

stration and Legislature, and media relations. The last of these becomes very important as the president is frequently sought out by the news media for comments on issues and stories dealing with public health and the practice of medicine.

A second responsibility of the president is to participate in policy development. The president serves as a member of the Board of Directors and as chair of the Executive Committee of the board. The Executive Committee filters and prepares some issues for the board and, when necessary, makes decisions for the society between board meetings. All of this requires frequent trips to Madison for board meetings, executive committee meetings, and frequent communication with SMS staff in Madison. The president is also an ex officio voting member of all committees of the State Medical Society and it is my intention to try and be present at a number of these meetings during the year.

The time commitment is great, the energy necessary is significant, and the effects on a physician's practice can persist long beyond the 1-year term. Not one of the former presidents that I spoke to, however, had any regrets about their year as president of the State Medical Society of Wisconsin.

I will "stay the course" set for me by my many predecessors. I am proud to be a physician and I am proud that you have chosen me to be president.[150th]



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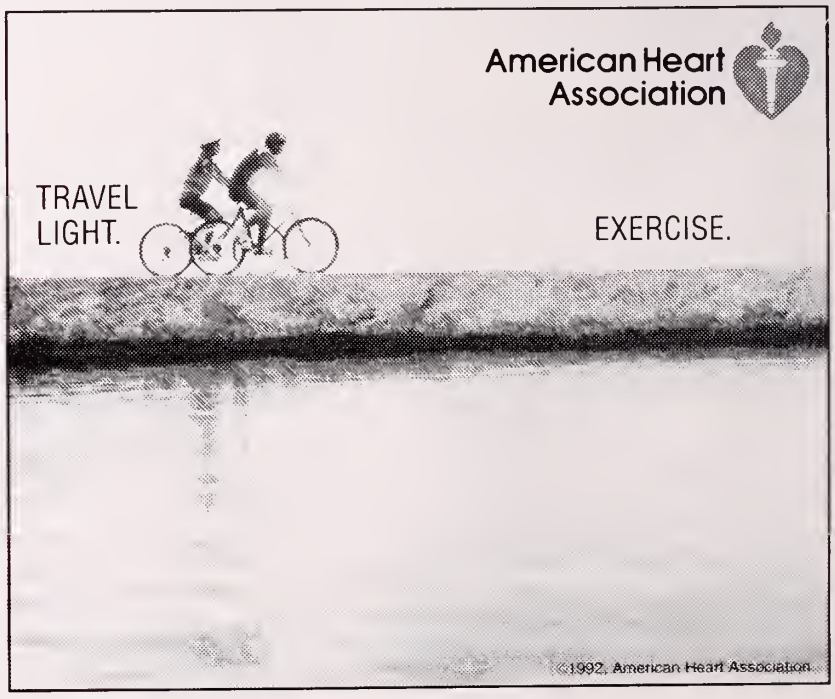

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CONTRAINDICATIONS: Zovirax Capsules, Tablets, and Suspension are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulations. **WARNINGS:** Zovirax Capsules, Tablets, and Suspension are intended for oral ingestion only. **PRECAUTIONS: General:** Zovirax has caused decreased spermatogenesis at high parenteral doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage should not be exceeded. Exposure of herpes simplex and varicella-zoster isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of herpes simplex or varicella-zoster virus to acyclovir and clinical response to therapy has yet to be established (see full prescribing information). Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy. Caution should be exercised when administering Zovirax to patients receiving potentially nephrotoxic agents since this may increase the risk of renal dysfunction. **Drug Interactions:** Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced. The clinical effects of this combination have not been studied. **Carcinogenesis, Mutagenesis, Impairment of Fertility:** The data presented below include references to peak steady state plasma acyclovir concentrations observed in humans treated with 800 mg given orally 6 times a day (dosing appropriate for treatment of herpes zoster) or 200 mg given orally 6 times a day (dosing appropriate for treatment of genital herpes). Plasma drug concentrations in animal studies are expressed as multiples of human exposure to acyclovir at the higher and lower dosing schedules (see full prescribing information). Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of up to 450 mg/kg administered by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. At 450 mg/kg/day, plasma concentrations were 3 to 6 times human levels in the mouse bioassay and 1 to 2 times human levels in the rat bioassay. Acyclovir was tested in two *in vitro* cell transformation assays. Positive results were observed at the highest concentration tested (31 to 63 times human levels) in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative (40 to 80 times human levels) in the other, possibly less sensitive, transformation assay. In acute cytogenetic studies, there was an increase, though not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of acyclovir (100 mg/kg) in rats (62 to 125 times human levels) but not in Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters (380 to 760 times human levels). In addition, no activity was found after 5 days dosing in a dominant lethal study in mice (36 to 73 times human levels). In all 4 microbial assays, no evidence of mutagenicity was observed. Positive results were obtained in 2 of 7 genetic toxicity assays using mammalian cells *in vitro*. In human lymphocytes, a positive response for chromosomal damage was seen at concentrations 150 to 300 times the acyclovir plasma levels achieved in man. At one locus in mouse lymphoma cells, mutagenicity was observed at concentrations 250 to 500 times human plasma levels. Results in the other five mammalian cell loci follow: at 3 loci in a Chinese hamster ovary cell line, the results were inconclusive at concentrations at least 1850 times human levels; at 2 other loci in mouse lymphoma cells, no evidence of mutagenicity was observed at concentrations at least 1500 times human levels. Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). In the mouse study plasma levels were 9 to 18 times human levels, while in the rat study they were 8 to 15 times human levels. At a higher dose in the rat (50 mg/kg/day, s.c.), there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day (16 to 31 times human levels). No effect upon implantation efficiency was observed when the same dose was administered intravenously (53 to 106 times human levels). In a rat peri- and postnatal study at 50 mg/kg/day s.c. (11 to 22 times human levels), there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F_1 generation. Although not statistically significant, there was also a dose-related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size (plasma levels were not measured). However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits (53 to 106 times human levels), no drug-related reproductive effects were observed. Intraperitoneal doses of 80 or 320 mg/kg/day acyclovir given to rats for 6 and 1 months, respectively, caused testicular atrophy. Plasma levels were not measured in the one month study and were 24 to 48 times human levels in the six month study. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. At 100 mg/kg/day plasma levels were 47 to 94 times human levels, while at 200 mg/kg/day they were 159 to 317 times human levels. No testicular abnormalities were seen in dogs given 50 mg/kg/day i.v. for one month (21 to 41 times human levels) and in dogs given 60 mg/kg/day orally for one year (6 to 12 times human levels). **Pregnancy: *Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rabbit (50 mg/kg/day, s.c. and i.v.) or in standard tests in the rat (50 mg/kg/day, s.c.). These exposures resulted in plasma levels 9 and 18, 16 and 106, and 11 and 22 times, respectively, human levels. In a non-standard test in rats, there were fetal abnormalities, such as head and tail anomalies, and maternal toxicity. In this test, rats were given 3 s.c. doses of 100 mg/kg acyclovir on gestation day 10, resulting in plasma levels 63 and 125 times human levels. There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in standard animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination. **Nursing Mothers:** Acyclovir concentrations have been documented in breast milk in two women following oral administration of Zovirax and ranged from 0.6 to 4.1 times corresponding plasma levels. These concentrations would potentially expose the nursing infant to a dose of acyclovir up to 0.3 mg/kg/day. Caution should be exercised when Zovirax is administered to a nursing woman. **Pediatric Use:** Safety and effectiveness in children have not been established. **ADVERSE REACTIONS–Herpes Simplex: *Short-Term Administration:*** The most frequent adverse reactions reported during clinical trials of treatment of genital herpes with orally administered Zovirax were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Nausea and/or vomiting occurred in 2 of 287 (0.7%) patients who received placebo. Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments with orally administered Zovirax (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat. **Long-Term Administration:** The most frequent adverse reactions reported in a clinical trial for the prevention of recurrences with continuous administration of 400 mg (two 200 mg capsules) 2 times daily for 1 year in 586 patients treated with Zovirax were: nausea (4.8%), diarrhea (2.4%), headache (1.9%) and rash (1.7%). The 589 control patients receiving intermittent treatment of recurrences with Zovirax for 1 year reported diarrhea (2.7%), nausea (2.4%), headache (2.2%) and rash (1.5%). The most frequent adverse reactions reported during the second year by 390 patients who elected to continue daily administration of 400 mg (two 200 mg capsules) 2 times daily for 2 years were headache (1.5%), rash (1.3%) and paresthesia (0.8%). Reactions reported by 329 patients during the third year include asthenia (1.2%), paresthesia (1.2%) and headache (0.9%). **Herpes Zoster:** The most frequent adverse reactions reported during three clinical trials of treatment of herpes zoster (shingles) with 800 mg of oral Zovirax 5 times daily for 7 to 10 days in 323 patients were: malaise (11.5%), nausea (8.0%), headache (5.9%), vomiting (2.5%), diarrhea (1.5%) and constipation (0.9%). The 323 placebo recipients reported malaise (11.1%), nausea (11.5%), headache (11.1%), vomiting (2.5%), diarrhea (0.3%) and constipation (2.4%). **Observed During Clinical Practice:** Based on clinical practice experience in patients treated with oral Zovirax in the U.S., spontaneously reported adverse events are uncommon. Data are insufficient to support an estimate of their incidence or to establish causation. These events may also occur as part of the underlying disease process. Voluntary reports of adverse events which have been received since market introduction include: ***General:*** fever, headache, pain, peripheral edema ***Digestive:*** diarrhea, elevated liver function tests, gastrointestinal distress, nausea ***Hemic and Lymphatic:*** leukopenia, lymphadenopathy ***Nervous:*** confusion, dizziness, hallucinations, paresthesia, somnolence ***Musculoskeletal:*** myalgia ***Skin:*** alopecia, pruritus, rash, urticaria ***Special Senses:*** visual abnormalities

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IMPROVING LIVES THROUGH
ANTIVIRAL RESEARCH

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Secretary's report

Only the inflexible die young

"TIMES ARE TOUGH." When I was a boy, my father uttered that phrase with some regularity. I never understood quite what he meant, although for a while I thought he was referring to having come through the Great Depression. As I look back on it, I think he meant that events in life are not always easy, not always happy, and when "times are tough" you have to be able to cope.

When I consider the number of calls the SMS receives regarding the alphabet soup of regulations and meteoric changes that govern the lives of modern physicians–RBRVS, OSHA, CLIA, HCFA, etc–I can see my father shaking his head and almost hear him saying "Times are tough."

These *are* tough times, and medicine must be ready to cope with them. Coping will mean seizing the reins of what we can control, and letting go of what we cannot. Survival does not go to the strongest, but to the fittest. The ability to adapt is often the difference between extinction and success. Only the inflexible die young.

The AMA and SMS have, obviously, spent a great deal of time and energy trying to influence the structure of the things that make these times tough, trying to keep them from becoming an unbearable burden, but they have taken their toll. There are dollars and cents sacrificed on the regulatory altar, but such are not their greatest costs. Frustration, aggravation, and precious time lost from direct patient care–these are the higher costs.

As I noted in my address to the SMS House of Delegates in April, nobody likes the current system of health care delivery and financing. Patients hate it, doctors hate it, insurance companies hate it, employers hate it, and politicians are learning to hate it. It wastes time. It wastes millions of precious health care dollars. It violates the physician-patient relationship. It threatens the financial strength of too many small businesses. It leaves too many people without coverage. It threatens the economic and physical health of too many families. And it encourages too many people to play shell games, shifting costs and responsibilities from one group to the next.

Physicians have been convenient scapegoats in this game of placing blame. It seems that sooner or later every player gets around to pointing at the big bad doctors. I've heard your complaints. I know of your compassion. I know of your charity. I know of your involvement in your communities. I know of your frustration with the bureaucracy that carves an ever greater chunk out of the time you want to devote to direct patient care. I know of your dislike of those who would paint you as adversaries of your patients, who try to build a wall of mistrust between you and the people you are trying to help.

Thomas L. Adams, CAE

Perhaps the time has come for bold action.

I believe the time has come to wipe the slate clean and begin an examination of the system's symptoms, the weaknesses that are causing those symptoms, and the wide range of possible cures. We must approach health care reform with the same scientific impartiality and methodology we would use in combating a new disease. We may have to challenge more than a few accepted notions and cherished expectations. We may have to adapt to a new way of practicing medicine. We won't know until we begin our study, but we must commence the process ready to accept what we find and to do what is necessary.

The SMS was a leader in creating and promoting the 12-point plan, Operation Reform, seven points of which were recently passed with the governor's small business health initiative by both houses of the Wisconsin Legislature. It was a good first step, but it was only a first step. A small step. The bill, AB 655, does have weaknesses. Most notably, it fails to address the crucial issues of tort reform and the continued inadequate funding of

Continued on next page

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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Continued from preceding page
medical assistance. We must continue to pursue our objectives in these areas, but we must also go farther.

I believe we must go much farther. We may not be able to create a system that will enhance the professional lives of every physician, and we may have to adapt to a system in which some medical practices are much different from what they are today. We have been told that physicians hold the key to successful health care reform, and to some extent that is true.

I believe that the leadership of this society has the foresight and knowledge to take the lead role in designing a unique Wisconsin response to reform of the health care delivery system. At the 1992 annual meeting, I proposed that this society form a task force of some of its best minds to study the possibilities, exercise their imaginations, and create the new Wisconsin idea.

The Task Force will attempt to address your frustration with the bureaucratic swamp of ever-changing regulations and ever-growing paperwork, as well as the walls that are being erected between you and your patients. But we must also address a number of issues that are extremely important to the other health care players, including overall costs, appropriate use of procedures and technology and physician fees. Disinterest, complacency and hesitation are inappropriate responses, for if we fail to address these issues, others will not.

Sure, times are tough. It is time to face our challengers and our challenges. It is time to create a health care systems reform plan that can not only spread the burdens and rewards of reform fairly among the players, but can win bipartisan support and actually pass into law. Medicine has long been accused of only being against things; now is the time, now is our opportunity, to say what medicine is for. We will need to free our thoughts of constraint and unleash our greatest, our most radical, creative abilities.[150th]

Soundings
Sickday

Jonathan Temte, MD, Madison

It is good,
when so small
and sick
and feverish,
to sit upon the big lap
of one so familiar
and know that the part of
the warmth you feel
is love.
And have the old cat
curl around to soothe
with contented purrs.
If I say that this
is an afternoon wasted,
I reveal my ignorance
of simple truth;
but if I
feel the warmth
and the quiet of this house,
I, too, am blessed.[150th]

Letters
A comment on breast reconstruction

To the editor: I would like to congratulate Luke Corsten, Dr Sandra Suduikis and Dr William Donegan on their succinct article titled "Patient satisfaction with breast reconstruction," which appeared in the March issue (*Wis Med J.* 1992;91(3):125-129).

I would just like to comment on the trend they observed in a higher percentage of women undergoing the tram flap reconstruction who report no complaints. Having done approximately 30 of these flaps, I can assure them that this trend is observed when one examines larger numbers of patients. It is a bigger operation, however, and many women prefer the apparently simpler procedure of placement of a silicone implant.

Of course, the FDA has imposed a moratorium on the use of the gel-filled implants and, it appears, will likely make this an investigational device. This will severely limit accessibility of reconstruction to women. I would simply encourage the readers to become familiar with this issue on a scientific level as opposed to the level that exists on talk shows on the various television networks.

–Paul W. Loewenstein, MD
Milwaukee[150th]

Correction

In the *Soundings* article by Dr Ralph Whaley (*Wis Med J.* 1992;92(3):123-124) part of a sentence in the second paragraph was omitted, and that omission changed the meaning of the sentence. The sentence "The natural response of providers is to pay very close attention to their primary work." should have read: "The natural response of providers is to pay very close attention to avoiding violating the regulations and less attention to their primary work." The *WMJ* regrets the error.[150th]

Posterior hip dislocation in a rural emergency department

Dean Stueland, MD, and Ronald R. Rothfusz, MD, Marshfield

Traumatic posterior dislocation of the hip is an infrequent but potentially severe injury. A commonly recognized cause of such injuries is motor vehicle accidents. There is increasing recognition, however, that this injury can be associated with other activities including several sports. Appropriate care requires recognition and prompt treatment to prevent long-term sequelae. A review of these experiences in a rural emergency department demonstrates additional causative agents and associated events as well as makes recommendations for care. *Wis Med J.* 1992;91(5):211-213.

Traumatic posterior dislocation of the hip is a severe but infrequent injury. Although these injuries are often due to motor vehicle accidents,[1,2] there is increasing recognition of this injury in several types of activities including athletic activities.[2-6] With the increasing spectrum of associated activities, this injury also is increasingly seen in children and young adults.

A recent observation of two of these cases prompted a review of our experience. The diagnostic file was searched for cases of traumatic posterior hip dislocation over the past 15 years. A summary of these cases is shown in the Table.

Two exemplary case reports follow.

Case reports

Case 9 is a 17-year-old boy involved in competitive wrestling. While trying to perform a "takedown," the other wrestler fell on the patient's left leg. The patient noted sudden and severe pain in his left hip. He denied other injuries and was transported on a backboard to the emergency department.

The patient was noted to be a muscular male who appeared to be in severe pain. He had normal vital signs and the general physical examination was normal except for his hip. His leg was in flexion with severe pain. Sensation to light touch and pedal pulses were normal.

In the emergency department, he received intravenous fluids, morphine, and lorazepam. The radiographs demonstrated a posterior dislocation of the left hip (Figure 1). Orthopedics was consulted and he was transferred to the operating room where, under general anesthetic, a reduction of the dislocation was done without complication.

He has recovered without further sequelae or complaints.

Case 10 is a 16-year-old boy who was thrown from the snowmobile he was riding and landed on his left side, and whose passenger, also thrown from the machine, landed on him. He noted sud-

Cases of traumatic posterior hip dislocation, presented in chronological order.

Case#	Age	Sex	Year	Activity	Associated Injury	Avulsion fracture of the acetabulum
1	8	M	1978	football	No	No
2	31	M	1979	hunting (fell from tree)	Yes[1]	Yes
3	29	M	1980	MVA (motorcycle)	Yes[2]	No
4	20	F	1987	MVA	Yes[3]	Yes
5	9	M	1988	football	No	No
6	52	M	1988	MVA	No	No
7	32	M	1988	farming (elevator fell on leg)	No	No
8	43	M	1989	MVA	Yes[4]	No
9	17	M	1990	wrestling	No	No
10	16	M	1990	snowmobile (thrown from)	No	Yes

[1] Ipsilateral wrist and acetabular factures.
[2] Ipsilateral tibial fracture.
[3] Ipsilateral tibial and fibular factures, cervical fracture (C5), and contralateral clavicle fracture.
[4] Ipsilateral rib fractures.

Dr Stueland and Dr Rothfusz are with the section of emergency medicine at the Marshfield Clinic/St Joseph's Hospital in Marshfield. Reprint requests to: Dean Stueland, MD, Marshfield Clinic/St Joseph's Hospital, 1000 N Oak, Marshfield, WI 54449. Copyright 1992 by the State Medical Society of Wisconsin.

den and severe pain in his left hip and was unable to bear weight. His passenger obtained help and the emergency medical technicians were called to the scene where he was found to have severe pain in his left hip. He was alert and cooperative, and actually willing to bear weight on his right leg. He was transferred to the emergency department on a backboard with his left leg flexed and in internal rotation to reduce discomfort.

On examination in the emergency department, the left leg was found to be flexed, internally rotated, and adducted. The results of the remainder of the physical examination were normal. The boy had normal pedal pulses of the left foot and normal sensation. He received intravenous fluids, morphine, and lorazepam. Radiographs verified the posterior dislocation, as well as an avulsion fracture of the inferior aspect of the acetabulum.

Case 10 was transferred to the operating room where the hip dislocation was reduced under general anesthetic. A subsequent CT scan of the left hip verified the fracture of the acetabulum, but there were no fragments within the joint space.

He has subsequently been followed as an out-patient and has had complete recovery of function without evidence of avascular necrosis by magnetic resonance imaging, as well as normal healing of the acetabular fracture.

Methods

Following the observation of the two above cases, we reviewed our medical records for cases of acute posterior hip dislocation seen in the past 15 years as shown in the accompanying table. Ten cases were found, with an age range of patients from 8 to 52 years. Nine of the 10 cases were men. Four were related to motor vehicle accidents (including a motorcycle accident), but six were related to other activities. In four, there were other associated orthopedic injuries, specifically including fractures, that also required immediate attention. There was an associated avulsion fracture of the acetabulum or femoral head in three cases.

Fig-AP pelvic radiograph showing posterior dislocation of the left hip.

Discussion

As in other studies, the majority of posterior hip dislocations occurred in men,[2,10] presumably because of the greater propensity to trauma. It has previously been reported that only 8% of hip dislocations occur in children, but in this series, four of the victims were less than 18 years old, including two boys that were aged 8 and 9.

There are a wide range of activities that are associated with posterior hip dislocation. Athletic activities in particular, including skiing,[3] football,[4,7] and rugby,[5,6] have been previously reported to be associated with posterior hip dislocation. Our review finds that wrestling should be added to that list.

The typical presentation of the patient with a posterior hip dislocation is with the leg in internal rotation and adduction.

Although the clinical presentation is typical, a delay in diagnosis may be a problem when there are other concurrent injuries that also require urgent attention.[4] Delayed diagnosis can lead to significant morbidity, including pain and nerve paresthesias. An associated acetabular avulsion fracture, if not adequately recognized, can lead to complications, including retained intra-articular fragment. Even if the plain radiographs do not suggest such a fracture, serious consideration should be given to a CT scan to rule out the avulsion fracture or a femoral head injury.[10,11]

Treatment of posterior hip dislocations involves closed manipulation and reduction, usually done under anesthesia or deep sedation. Open reduction may be required if closed reduction fails or if there are significant associated fractures.

The most important long-term complication after posterior hip dislocation is the development of avascular necrosis of the femoral head, which has been estimated to occur in about 10% of cases. Other complications include accelerated degenerative arthritis of the hip.[12] Complications are more likely to occur if there

has been severe trauma or delay in reduction.

Summary

Although traumatic posterior hip dislocation is a relatively rare event, it is necessary for emergency physicians, including those working in a rural area, to be aware of this injury. The type of activities associated with this complication appear to be increasing.

For optimal outcome, it is necessary for the emergency physician to recognize this injury. In addition to managing the associated trauma, appropriate radiographs need to be obtained to verify the dislocation and any associated injuries of the pelvis, acetabulum, or femoral head. Serious consideration should be given to the use of CT scanning to further delineate the injuries. The specific activities that may be associated with the injury vary greatly, and the emergency physician needs to be aware of the spectrum of trauma which in that community may be associated with this injury. Prompt recognition and referral for reduction, often under anesthesia, helps to reduce the incidence of subsequent complications.

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AIR FORCE

Acute adrenal insufficiency: hemodynamic and echocardiographic characteristics

John M. Lawton, MD, Green Bay

A patient with high output circulatory failure due to acute secondary adrenal insufficiency is described. The hemodynamic similarities and echocardiographic differences between volume expanded cortisol deficiency and septic shock are identified. *Wis Med J.* 1992;91(5):214-216.

Shock is a common problem in critically ill patients. Knowledge of the hemodynamic profiles of the various shock syndromes allows identification of potential causes leading to directed empiric treatment prior to specific diagnosis. Categories of various shock syndromes are outlined in standard textbooks.[1]

Cortisol deficiency is frequently placed in the category of volume depletion. This is based on the physiology of chronic adrenal insufficiency in which hypotension is due volume depletion as a result of renal sodium losses.

Applying these concepts to the critically ill may lead to difficulties. Three cases of high output shock due to cortisol deficiency have previously been reported.[2,3] These cases were due to primary adrenal insufficiency.

The patient described in this report had high output shock due to secondary adrenal insufficiency. In addition this case provided the unique opportunity to determine the echocardiographic characteristics of acute adrenal insufficiency in the volume expanded patient which has not been previously described.

Case report

A 30-year-old man involved in a snowmobile accident suffered severe head injuries and multiple fractures. He was comatose, and required mechanical ventilation. Three weeks after admission, he remained comatose and underwent tracheostomy and facial surgery without complication. Several hours after the procedures, he developed progressive decrease in blood pressure despite adequate intravacular volume as determined by central venous pressure of 18 cm of water.

Blood cultures were obtained, and empiric antibiotics were instituted. Dopamine was initiated with a dose of 15μg/Kg per minute, required to maintain a systolic blood pressure of 90 mm Hg.

Acute oliguric renal failure developed, and the patient was evaluated for possible hemodialysis. Prior to initiating hemodialysis, hemodynamic characterization of the shock state was accomplished with pulmonary artery catheterization and two dimensional echocardiographic evaluation. The plasma cortisol level was also obtained. Cardiac output by thermodilution was 13 L per minute while pulmonary capillary wedge pressure was 18 mm Hg. Calculated systemic vascular resistance was 137 dynes per $sec/cm^{-5} \cdot m^2$. An echocardiogram revealed normal left ventricular systolic motion and chamber size. Rapid determination of cortisol was requested and the level returned at 1.2 μg/mL.

With this information, 100 mg of hydrocortisone was administered intravenously, and dialysis was iniatiated. Dopamine requirements rapidly decreased and dialysis was accomplished without complication. Hydrocortisone was continued at an IV dose of 100 mg every 4 hours. Six hours after the first dose of steroid replacement, dopamine was no longer required to maintain a systolic blood pressure of greater than 100 mm Hg. With the rise in blood pressure, urine output increased and renal function rapidly improved with no further dialysis required.

A subsequent endocrinologic evaluation revealed low levels of thyroxine by direct dialysis technique, ultrasensitive thyrotropin, luteinizing hormone, follicle stimulating hormone, and testosterone. A CT scan of the abdomen revealed normal adrenal glands with no evidence for hemorrhagic destruction. The results of his blood cultures were negative for bacterial growth. The patient gradually improved neurologically and was ultimately discharged on replacement doses of cortisone, thyroid, and testosterone.

Discussion

This case demonstrates high-output low-resistance shock in the volume expanded cortisol deficient state. The etiology of the low cortisol state was acute secondary adrenal insufficiency as a result of traumatic pituitary dysfunction. This diagnosis is supported by the findings of low levels of thyrotropin, thyroxine, testosterone, follicle stimulating hormone and luteinizing hormone, as well as the very low serum cortisol level. The rapid resolution of hypotention with IV hydrocortisone provides confirmatory evidence that cortisol deficiency was, indeed, the cause of the shock syndrome. Hydrocortisone was selected for steroid replacement rather than dexamethasone with simultaneous diagnostic corticotropin stimulation because of the high clinical suspicion of secondary adrenal insufficiency. Three previous cases have described similar cardiovascular profiles in acute primary adrenal failure but this is the first report of such events in secondary adrenal insufficiency. In addition, the echocardiographic features of the volume expanded cortisol deficient state have not been previously reported.

These issues are important for those caring for the critically ill. Classic, and thus commonly understood, clinical pat-

Dr Lawton is the medical director of the Regional Kidney Dialysis Program at St Vincent Hospital in Green Bay. Reprint request to: John Lawton, MD, 704 Webster, Green Bay, WI 54301. Copyright 1992 by the State Medical Society of Wisconsin.

terns of disease can undergo major alterations by standard intensive care management, making their recognition quite difficult. The cause of hypotention in untreated chronic adrenal insufficiency is volume depletion exacerbated by depressed cardiac function.[4] Hemodynamic monitoring with assurance of adequate intravascular volume can obscure these findings.

The patient described in this report underwent routine evaluation and treatment for shock in a modern intensive care unit, yet specific diagnosis was not initially obtained. Invasive monitoring with volume expansion to maximize preload and thus cardiac output were rapidly achieved. The cardiovascular profile at that point was one of high cardiac output low-resistance shock identical to that seen in septicemia. Without the information obtained from rapid plasma cortisol determination the patient could certainly have been treated with empiric antibiotics awaiting culture results. Such a course of treatment would have resulted in further multisystem deterioration.

The case underscores the several mechanisms through which adrenal steroids maintain blood pressure. Mineralocorticoids maintain intravascular volume through their effects on renal sodium handling. Cortisol appears to exert a permissive effect on the production and action of endogenous catecholamines and possibly through an inhibitory effect on the production of the vasodilator prostacyclin.[5,6,7] In addition, chronic adrenal steroid deficiency results in depressed cardiac function further exacerbating the other mechanisms of hypotension. In secondary adrenal insufficiency the loss of mineralocorticoid effect would be insignificant due to the continued production of aldosterone. Thus, the hemodynamic effect of acute secondary adrenal insufficiency or the volume expanded primary disorder is to cause hypotension by decreasing peripheral vascular resistance.

Treating either condition with volume alone will not compensate for the lack of vascular tone resulting in continued hypotension. Furthermore, such treatment is not only ineffective but also alters the cardiovascular profile mimicking the more common condition of sepsis. Failure to understand the potential evolution of this form of shock from a hypovolemic pattern to a high-output picture can lead to delay in treatment with deleterious results.

Additional information derived from this case are the echocardiographic features of volume expanded acute adrenal insufficiency. Normal ventricular func-

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tion and chamber size were well demonstrated. These findings contrast with the decreased contractility and dilated chamber size frequently found in patients with septic shock.[8,9] The contrasting echocardiographic patterns could serve as a potential aid in the early differential diagnosis between these two similar forms of the shock syndrome.

The recognition that high cardiac output, low-resistance shock syndrome can occur in secondary adrenal insufficiency stresses the importance of considering the adrenocortical status of patients in shock of unclear etiology.

Primary adrenal insufficiency due to adrenal hemorrhage and secondary insufficiency form head trauma and steroid withdrawal can occur in the critically ill patient. These patients will usually be kept volume replete due to close monitoring of cardiovascular status obscuring the classic signs of adrenal insufficiency. If the diagnosis is not considered and specifically searched for it will be missed with serious consequences.

Thus, in patients with the hemodynamic profile of sepsis, the adrenocortical status should be considered and specifically evaluated if the clinical circumstances suggest the possibility of adrenal insufficiency.

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Blood-borne pathogens: An overview of OSHA standards and an exposure control plan

This special section has been bound separately so that you may easily remove it from the *Wisconsin Medical Journal* and file it for reference.

OSHA blood-borne pathogens standard: an overview

Since its publication Dec 6, 1991, the Occupational Health and Safety Administration's (OSHA) *Occupational Exposure to Bloodborne Pathogens Standard* has slowly gained recognition among health care providers and others within its broad scope as a massive and costly piece of regulation. Although the intent behind this law is honorable, the actual cost of regulation will far exceed the federal agency's estimate of $821 million. This explanation of the standard is part of the SMS's effort to assist physicians in complying with the OSHA regulations that included five seminar programs held throughout the state and instructed by state OSHA experts in April. Further assistance is available through the resources listed at the end of this article.

AIDS and hepatitis B merit serious concern for workers occupationally exposed to blood, other potentially infectious materials, and other body fluids that contain blood-borne pathogens such as the human immunodeficiency virus (HIV) and the hepatitis B virus (HBV). Given current statistics on HIV seroprevalence that indicate approximately one in 100 adult males and one in 800 adult females carry HIV, the risk of exposure to health care workers is quite real. According to OSHA estimates, more than 5.6 million workers in health care and public safety occupations could potentially be exposed to these viruses.

Health care workers identified by OSHA include, but are not limited to: physicians, dentists, dental employees, phlebotomists, nurses, morticians, paramedics, medical examiners, laboratory and blood bank technologists and technicians, housekeeping personnel, laundry workers, employees in long-term care facilities, and home care workers. Other workers who may be exposed to blood or other potentially infectious materials, depending on their work assignments, include research laboratory workers, public safety personnel (fire, police, rescue, correctional officers), and employees providing first aid at industrial work sites.

Exposure to blood-borne pathogens may occur in many ways. Although needlestick injuries are the most common means of exposure for health care workers, blood-borne pathogens also can be transmitted through contact with the mucous membranes and non-intact skin of workers.

In response to the concern regarding transmission of HIV, HBV, and other blood-borne pathogens, OSHA has put into place work-place standards with which all physicians who employ one or more persons must comply. The effective date of this standard was March 6, 1992, with a final date of July 6, 1992, for a series of phased implementation steps. Physicians have the legal obligation to inform their employees of OSHA safety and health standards which apply to their work place.

Scope and application

The new standard applies to all occupational exposure to blood and other potentially infectious materials. It covers all blood-borne pathogens, not just HIV and hepatitis B virus.

Definitions

There are several terms defined in the standard that physicians must know. These critical definitions follow.

Occupational exposure means "reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties." The standard is not limited to health care facilities and applies wherever there is a "reasonably anticipated" occupational exposure, even though there has been no history of exposure.

Parenteral is defined to include human bites and parenteral contact is part of the definition of occupational exposure. This means that police and correctional officers are also covered by this standard.

Other potentially infectious materials (OPIM) includes: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids. This definition also includes infected tissues, organs, teeth, and HIV and HBV cell and tissue cultures.

The Wisconsin Department of Natural Resources (DNR) definition of infectious waste is "solid waste which contains pathogens with sufficient virulence and quantity so that exposure to the waste by a susceptible host could result in an infectious disease. The OSHA definition of *regulated waste* goes beyond the DNR definition of infectious waste. (See "Wisconsin's infectious waste regulations," *Wis Med J*.1990;89(6):275.) The OSHA definition includes not only material that is pourable, drippable, or squeezable, but flakeable as well, ie, "items that are caked with dried blood or OPIM and are capable of releasing these materials during handling."

Contaminated laundry means laundry which has been soiled with blood or OPIM or may contain sharps.

Exposure control plan

A key provision of the new standard is its exposure control plan. The employer is responsible for preparing an exposure determination to see which employees are covered by the standard. The exposure control plan must list the job classifications in which all employees have occupational exposure and list those job classifications in which only some employees have occupational exposure. This second category requires an analysis of those tasks where occupational exposure occurs and list each task that poses a reasonably anticipated risk. It is simpler for employers to establish new job classifications based on exposure rather than

performing a task for the entire job class to avoid this additional analysis. For example, janitorial workers may be divided into those with anticipated exposure (patient care areas) and those who do not have exposure (common areas and offices). This difference would have to be reflected in the new job title.

The plan must also set forth the schedule for implementing the other requirements of the standard and specify the procedure for evaluating circumstances surrounding exposure incidents. The plan must be accessible to employees and available to OSHA. Employers must review and update it at least annually and more often if necessary to accommodate work place changes.

Methods of compliance

The general underlying principle for compliance is universal precautions, which are mandated by this standard. Engineering and work practice controls shall be used first to minimize exposure. Washing hands is stressed and employers must provide hand-washing facilities and ensure that employees use them following exposure to blood or body fluids. Other changes include regular examination, maintenance and replacement schedule for engineering controls; prohibitions on recapping needles except under certain limited circumstances; accessibility of sharps containers; prohibitions on eating, drinking, applying of cosmetics in areas where there is potential exposure; prohibitions on food storage in the presence of blood or OPIM; transporting of specimens in covered containers; and a requirement that equipment that is contaminated with blood or OPIM be decontaminated or labeled as contaminated if it is impossible to decontaminate it before it is sent for repair or maintenance.

When exposure cannot be controlled by these engineering and work-place practices, the standard requires the use of personal protective equipment (PPE). Employers must require the employee to use, at no cost to the employee, appropriate PPE such as gloves, gowns, masks, mouthpieces and resuscitation bags. Employers must also clean, repair, replace and dispose of these PPE when necessary. If the employee's uniform is PPE (ie, scrubs), then the employer must purchase and launder these uniforms. If the employee wears his or her uniform as street clothes and another garment (ie, lab coat), is used as PPE, the employer is responsible only for the lab coat and not the uniform.

The use of gloves is now extended to phlebotomy and other vascular access procedures. The only exemption is for employees in volunteer blood donation centers. All other employees performing phlebotomies in all other settings must wear gloves.

The standard requires a written schedule for cleaning, identifying the method of decontamination to be used, in addition to cleaning following contact with blood or other potentially infectious materials. It specifies methods for disposing of contaminated sharps and sets forth standards for containers for these items and other regulated waste. Cleaning agents for areas contaminated with blood or OPIM must be tuberculocidal disinfectants, not merely HIV-effective. Lists of approved disinfectants are available from the EPA.

The laundry section now requires that contaminated laundry be labeled as biohazard or that, in facilities with universal precautions in place, an alternative recognized color coding system be used. Any contaminated laundry sent off-site must be labeled biohazard or red bagged.

Hepatits B vaccination

This provision requires HBV vaccinations to be made available to all employees who have occupational exposure to blood within 10 working days of initial assignment after receiving required training. The vaccination can be of no cost to the employee, meaning no cost-sharing (co-payment, deductible or passed on as a premium increase) as a service provided under an employee health plan. The employer may not institute a program in which the employee pays the original cost of the vaccine and is reimbursed if he or she remains employed for a specified time. The vaccinations must be given at a reasonable time and place, under the supervision of a licensed physician, and according to the latest recommendations of the US Public Health Service. Screening may not be required as a condition of receiving the vaccine. Employees must sign a declination form if they choose not to be vaccinated, but may at any time later decide to receive the vaccine at no cost to the employee. This form must contain the exact wording provided by OSHA (see below). Should booster doses later be recommended by the USPHS, they must be offered to employees.

Declination statement

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____ _____

Employee Signature Date

Post-exposure evaluation

This section specifies procedures to be made available to all employees who have had an exposure incident. Follow-up must include a confidential medical evaluation documenting the circumstances of exposure, identifying and testing the source individual if feasible, testing the exposed employee's blood if he or she consents, post-exposure prophylaxis, counseling and evaluation of reported illnesses. If the exposed employee agrees to baseline blood collection but not to HIV testing, the blood sample must be preserved for at least 90 days, during which time it can be used for testing should the employee wish it. Employers may not have access to the results of any test or examination performed of either the employee or source individual. If the employer is also the employee's health care provider, all results must be kept confidential. If post-exposure follow-up is administered through employee health services, those results remain confidential and are not available to the general administration. OSHA will address this situation in a later document. The results of the source individual's test, however, must be made available to the exposed employee.

Any costs associated with post-exposure follow-up, prophylaxis, counseling and evaluation of reported illnesses must be paid by the employer.

Hazard communication

This section requires that biohazard warning labels be attached to regulated waste containers, refrigerators and freezers containing blood or OPIM, to name a few. The label shall be fluorescent orange or orange-red with lettering or symbols in a contrasting color. Red bags can substitute for a labeled bag. As discussed earlier, contaminated equipment must be labeled appropriately. When a facility uses universal precautions in its handling of all specimens, labeling is not required within the facility. Likewise, when all laundry is handled with universal precautions, the laundry need not be labelled. If equipment, specimens or laundry is sent out of the facility for services, labeling requirements must be observed to warn the outside service of potential infectious hazards.

Employee training

All employees covered by the standard must be trained during work hours at no cost to the employee. Training regarding this standard must be given at the time of initial assignment and at least annually thereafter. Training must include making accessible: a copy of the regulatory text of the standard and an explanation of its contents; a general discussion on blood-borne diseases and their transmission, the exposure control plan, the engineering and work practice controls, personal protective equipment, hepatitis B vaccine, response to emergencies involving blood, how to handle exposure incidents, the post-exposure evaluation and follow-up program, and the signs, labels, and color-coding associated with laundry, specimens and waste. Material must be appropriate in content and vocabulary to the education level, literacy, and language of employees.

The training must provide an opportunity for interactive questions and answers with the person conducting the training session; therefore, an employer cannot train by video or computer alone. The person conducting the training must be knowledgeable in the subject matter, as it relates to the particular work place.

Recordkeeping

Records of all employee exposures must be kept. The record shall include the employee name; Social Security number; copy of HBV vaccinations status, including dates; results of any examinations, medical testing and follow-up procedures; a copy of the health care professional's written opinion; and a copy of information provided to the health care professional. These records must be kept confidential and kept for the length of employment, plus 30 years. Employers with fewer than 10 employees are not required to maintain the OSHA 200 logs for recording and classifying recordable occupational injuries and illnesses.

Records must also be kept of all employee training. These records must include the dates of the training sessions, content, names and qualifications of trainers, and names and job titles of attendees. These records must be kept for 3 years from the date of training.

Effective dates

The standard became effective March 6, 1992. Facilities must have had their exposure control plan in place by May 5, 1992. The information, training and recordkeeping provisions must be met by June 4, 1992. All other provisions of the standard, including engineering and work practice controls, PPE, housekeeping, HBV vaccination, post-exposure follow-up, and labels and signs go into effect July 6, 1992.

Inspections and penalties

OSHA is empowered under law to conduct general compliance inspections of facilities on a routine scheduled basis. The agency has given priority to making site inspections when the health of employees is in imminent danger, there has been a report of a fatality or catastrophe, and upon receiving an employee complaint. OSHA also accepts complaints brought by reporters other than employees, but gives these reports lowest priority. In this last case, OSHA will issue a letter to the employer asking for a response to the complaint. An employer's failure to respond to an OSHA letter of inquiry within the 10 days provided may result in an OSHA inspection. If after addressing these priority situations there is time left, OSHA inspectors will conduct scheduled inspections.

Under the most recent federal budget reconciliation act, OSHA is authorized to assess the following civil penalties:

- willful or repeated violation, $70,000;
- serious or other-than serious violation, $7,000;
- posting requirements, $7,000; and
- failure to abate (daily penalty), $7,000.

OSHA may issue a citation for violations that are not serious without a civil penalty, but the employer must correct the hazard cited by OSHA. In addition to the maximum violations above, OSHA inspectors may assess civil penalties for reporting and recordkeeping violations, including refusing to allow OSHA officials

access to records, which may result in a base penalty of $1,000.

Resources

In addition to the material provided with this article, persons interested in more information about the OSHA blood-borne pathogen standard may contact the offices and agencies listed below. The SMS is making its OSHA seminar reference book available to SMS members and staff for $25, plus applicable state and local sales tax. This reference guide includes 175 pages of OSHA materials and guides, including the standard and the compliance directive which will be used by OSHA inspectors, and the model exposure control plan included with this article. Persons interested in receiving reference materials or who have questions about the standard may contact the SMS Division of Medical Policy and Practice.

The Wisconsin Department of Health and Social Services' Division of Health, Section of Occupational Health, in conjunction with the US Department of Labor, offers free on site consultation to assist Wisconsin employers in meeting the OSHA requirements. Employers using this service are obligated to take necessary corrective actions where consultants find a job hazard. To request this service or to inquire further, please call (608) 266-0417.

The regional OSHA office for Wisconsin may be contacted by writing to: Region V, 230 S Dearborn St, 32nd Floor, Room 3244, Chicago, IL 60604, or by calling (312) 353-2220.

As another reference, the National Institute for Occupational Safety and Health (NIOSH) can provide free information on the potential dangers of work place substances. If requested, NIOSH will keep confidential the name of the person asking for assistance or information. The address is: National Institute for Occupational Safety and Health, Centers for Disease Control, Atlanta, GA 30333.

Common questions

Q. To meet requirements for recordkeeping, how do we count the number of employees we have?

A. As stated in the article, employers with fewer than 10 employees do not need to record employee work-related injuries and illnesses in the OSHA 200 log. Physician shareholders of a medical service corporation would be considered employees even though the physicians legally act as the employer. Also, OSHA interprets the 10 employee threshold to be met at any time during the calendar year when 10 or more workers are employed and does not allow the employer to average its work force over the year.

Q. If our clinic contracts with an outside cleaning service, who is responsible for the OSHA housekeeping requirements concerning the cleaning service employees?

A. If the cleaning service work is performed by a team with its supervisor on site, the cleaning service will be responsible for complying with the OSHA requirements. The clinic, however, will be responsible for protecting individual custodial workers. Regardless of which situation applies, the medical office should alert the cleaning service to possible hazards.

Q. At our facility, staff are certified in CPR even though they may not be involved in providing health care. Must our clinic include them in our exposure control plan if they may be involved in providing care which would otherwise be defined as "occupational exposure" although this is not an assigned duty?

A. "Good Samaritans" are excluded from the OSHA regulations and employees who provide care in an emergency but are not assigned to perform this function as part of their job are not covered. OSHA encourages employers to offer follow-up exposure control procedures in instances when an employee is exposed while giving emergency aid.

Q. We have been told that if a courier picks up clinic patient laboratory specimens we are sending to a referral lab, we are exempt from the OSHA labeling requirements. Is this true?

A. No. A clinic is required to label any blood or other potentially infectious materials and this responsibility does not end because another entity provides transportation of the materials.

Q. Must employees giving immunizations and other intramuscular injections wear gloves? What about fingersticks?

A. Immunization shots are not considered "vascular access procedures" as defined by the regulations as requiring employees to wear gloves. Fingersticks, however, do fall into this category and employees performing this procedure would be required to wear gloves.

Q. What is considered a "work area" that may be subject to contamination by blood-borne pathogens?

A. Generally, areas where occupational exposure may occur are considered part of the work area and may include nursing stations, corridors and other areas blood and OPIM may be expected to contaminate. In an industrial work place, the work area regulated by the standard would be the first aid station. Areas otherwise accessible by non-exposed employees and the public are not covered, nor are employee break areas so long as blood and OPIM are not permitted in those areas. (For example, the employee refrigerator may not be used to store specimens.) Employees who have been exposed are not permitted to leave work areas without first removing potentially contaminated PPE or washing their hands. It is not permitted, for example, for a laboratory employee to use a public telephone wearing contaminated gloves.

Q. Is used examining table paper and other waste considered potentially

infectious waste that requires special handling and disposal?

A. No. Unless the waste contains blood or other potentially infectious waste which is drippable, pourable, squeezable or flakeable, it does not need to be specially handled or disposed. Since disposing infectious waste is expensive, it is a good idea to separate non-infectious waste like paper, gauze and dressings not meeting this definition from the infectious waste stream. For a more specific definition of drippable, pourable, squeezable or flakeable blood or OPIM, contact the Region V OSHA office listed previously or the DNR Solid Waste Division.

Q. Are used gloves and other PPE considered infectious waste?

A. Just as in the above question, only gloves and other personal protective equipment that is contaminated with drippable, pourable, squeezable or flakeable blood or OPIM must be handled as infectious waste.

Q. Can we allow employees to launder their own uniforms?

A. If the employee has occupational exposure and uses the uniform as personal protective equipment, the employer may not permit the employee to launder their uniforms. If the employee wears the uniform under PPE provided by the employer (ie, scrubs), the employer need not provide laundering services for the personal uniforms.

Q. What if an employee disagrees with the employer about his or her classification under the exposure control plan (for example, he or she believes there is occupational exposure but is not included as such in the plan)?

A. As mentioned in the article, OSHA will respond to employee complaints with a site inspection if warranted. Therefore, there is a risk of facing a full OSHA inspection if an employer fails to address an employee's concern about their classification.

Q. Are volunteers covered by the OSHA Standard?

A. Although volunteers are not covered, OSHA will broadly interpret the term "employee" when determining compliance. Under OSHA and other federal definitions, a volunteer will be considered an employee if there is any remuneration provided by the employer, including free meals, uniforms, discounted services or other measurable benefits. Students, however, are not covered by OSHA.

Q. Are independent contractors like non-employee physicians providing services to a free standing clinic or hospital under contract considered employees?

A. If the physicians are truly independent contractors, the health care facility will not be required to comply with the training, vaccination, and post-exposure counseling and evaluation for the physician or the physician's employees. The facility will be expected, however, to provide PPE and work place controls required by the Standard.

Q. Who may administer the employer's vaccination program?

A. The OSHA regulations defer to state licensing laws concerning who may administer HBV vaccines and supervise the HBV immunization program. In Wisconsin, only physicians (MDs and DOs) may supervise the immunization program, but may delegate this responsibility to a properly trained health care professional.

Q. Are sample training programs meeting the OSHA requirements available?

A. The state OSHA consultation section has no sample training program available at this time. Training programs are available on the private market place, including a program designed by the AMA. These programs may not fulfill the requirement that the employer provide an interactive session where employees may ask questions of a knowledgeable trainer. Medical offices may find it useful to contact area hospitals for this technical assistance.

For more information, please see the previous listed references.

Sample blood-borne pathogen exposure control plan

Wisconsin Department of Health and Social Services, Division of Health,
Bureau of Public Health, Section of Occupational Health, OSHA Consultation Program

THIS DOCUMENT relies heavily on draft plans from Occupational Safety and Health Administration Region III and the Indian Health Service and is provided only as a guide to assist in complying with 29 CFR 1910.1030, OSHA's blood-borne pathogens standard. It is not intended to supersede the requirements detailed in the standard. Employers should review the standard for particular requirements which are applicable to their specific situation. It should be noted that this model program does not include provisions for HIV/HBV laboratories and research facilities which are addressed in section (e) of the standard. Employers operating these laboratories need to include provisions as required by the standard. Employers will need to add information relevant to their particular facility to develop an effective, comprehensive exposure control plan. Employers should note that the exposure control plan is expected to be reviewed at least on an annual basis and updated when necessary.

These materials, as well as safety and health consultation services, are provided free of charge to owners, proprietors, and managers of small businesses, by the Wisconsin Department of Health and Social Services under a program funded largely by the OSHA.

The information contained in this document is not considered a substitute for any provision of the standard.

Contents

A. Purpose 226
B. Exposure determination 226
C. Implementation schedule and methodology 226
  1. Compliance methods 226
  2. Needles 227
  3. Containers for reusable sharps 227
  4. Work area restrictions 227
  5. Specimens 227
  6. Contaminated equipment 228
  7. Personal protective equipment 228
    PPE provision 228
    PPE use 228
    PPE accessibility 228
    PPE cleaning, laundering and disposal 228
    Gloves 228
    Eye and face protection 229
    Additional protection 229
  8. Housekeeping 229
  9. Regulated waste disposal 229
    Disposable sharps 229
    Other regulated waste 230
  10. Laundry procedures 230
  11. Hepatitis B vaccine and post-exposure evaluation and follow-up 230
    General 230
    Hepatitis B vaccination 230
    Post-exposure evaluation and follow-up 230
    Information provided to the health care professional 231
    Health care professional's written opinion 231
  12. Labels and signs 231
  13. Information and training 232
  14. Keeping records 232
    Medical records 232
    Training records 232
    Availability 233
    Transfer of records 233
  15. Evaluation and review 233
  16. Dates 233
  17. Outside contractors 233

Blood-borne pathogens exposure control plan

Facility name: _____
Date of preparation: _____

In accordance with the OSHA blood-borne pathogens standard, 29 CFR 1910.1030, the following exposure control plan has been developed:

A. Purpose

The purpose of this exposure control plan is to eliminate or minimize employee occupational exposure to blood or certain other body fluids, and to comply with the OSHA blood-borne pathogens standard, 29 CFR 1910.1030.

B. Exposure determination

OSHA requires employers to perform an exposure determination concerning which employees may incur occupational exposure to blood or other potentially infectious materials. The exposure determination is made without regard to the use of personal protective equipment (ie, employees are considered to be exposed even if they wear personal protective equipment). This exposure determination is required to list all job classifications in which all employees may be expected to incur such occupational exposure, regardless of frequency. At this facility the following job classifications are in this category:
(list job classifications)

_____
_____
_____

In addition, OSHA requires a listing of job classifications in which some employees may have occupational exposure. Since not all the employees in these categories would be expected to incur exposure to blood or other potentially infectious materials, task or procedures that would cause these employees to have occupational exposure are also required to be listed to clearly understand which employees in these categories are considered to have occupational exposure. The job classifications and associated tasks for these categories are as follows (or place in appendix):

Job classification	Task or procedure

C. Implementation schedule and methodology

OSHA also requires that this plan include a schedule and method of implementation for the various requirements of the standard. The following complies with this requirement:

1. Compliance methods

Universal precautions will be observed at this facility to prevent contact with blood or other potentially infectious materials. All blood or other potentially infectious material will be considered infectious regardless of the perceived status of the source individual.

Engineering and work practice controls will be used to eliminate or minimize exposure to employees at this facility. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be used. At this facility the following engineering controls will be used: (list controls, such as sharps containers, biosafety cabinets, etc).

_____
_____
_____

The above controls will be examined and maintained on a regular schedule. The schedule for reviewing the effectiveness of the controls is as follows: (list schedule such as daily, once a week, etc, as well as list who has the responsibility to review the effectiveness of the individual controls, such as the supervisor for each department, etc).

_____

_____

_____

Hand-washing facilities shall be made available to the employees who incur exposure to blood or other potentially infectious materials. OSHA requires that these facilities be readily accessible after incurring exposure. (If hand-washing facilities are not feasible, the employer is required to provide either an antiseptic cleanser in conjunction with clean cloth or paper towels or antiseptic towelettes. If these alternatives are used then the hands are to be washed with soap and running water as soon as feasible. Employers who must provide alternatives to readily accessible hand-washing facilities should list the location, tasks, and responsibilities to ensure maintenance and accessibility of these alternatives.)

_____ (insert name of position or person, eg, supervisors) shall ensure that after the removal of personal protective gloves, employees shall wash hands and any other potentially contaminated skin area immediately or as soon as feasible with soap and water.

_____ (insert name of position or person, eg, supervisors) shall ensure that if employees incur exposure to their skin or mucous membranes then those areas shall be washed or flushed with water as soon as feasible following contact.

2. *Needles*

Contaminated needles and other contaminated sharps will not be bent, recapped, removed, sheared or purposely broken. OSHA allows an exception to this if the procedure would require that the contaminated needle be recapped or removed and no alternative is feasible and the action is required by the medical procedure. If such action is required then the recapping or removal of the needle must be done by the use of a mechanical device or a one-handed technique. At this facility recapping or removal is only permitted for the following procedures: (list the procedures and also list the mechanical device to be used or alternately if a one-handed technique will be used).

_____

_____

_____

3. *Containers for reusable sharps*

Contaminated sharps that are reusable are to be placed immediately, or as soon as possible, after use into appropriate sharps containers. At this facility the sharps containers are puncture resistant, labeled with a biohazard label and are leak proof. (Employers should list here where reusable sharps containers are located as well as who has responsibility for removing sharps from containers and how often the containers will be checked to remove the sharps.)

4. *Work area restrictions*

In work areas where there is a reasonable likelihood of exposure to blood or other potentially infectious materials, employees are not to eat, drink, apply cosmetics or lip balm, smoke, or handle contact lenses. Food and beverages are not to be kept in refrigerators, freezers, shelves, cabinets, or on counter tops or bench tops where blood or other potentially infectious materials are present.

Mouth pipetting or suctioning of blood or other potentially infectious materials is prohibited.

All procedures will be conducted in a manner which will minimize splashing, spraying, splattering, and generation of droplets of blood or other potentially infectious materials. Methods which will be employed at this facility to accomplish this goal are: (list methods, such as covers on centrifuges, usage of dental dams if appropriate, etc).

5. *Specimens*

Specimens of blood or other potentially infectious materials will be placed in a container which prevents leakage during the collection, handling, processing, storage, and transport of the specimens.

The container used for this purpose will be labeled or color coded in accordance with the requirements of the OSHA standard. (Employers should note that the standard provides for an exemption for specimens from the labeling and color coding requirement of the standard provided that the facility uses universal precautions in the handling of all specimens and the containers are recognizable as containing specimens. This exemption applies only while the specimens remain in the facility. If the employer chooses to use this exemption then it should be stated here. _____)

Any specimens which could puncture a primary container will be placed within a secondary container which is puncture

resistant.

If outside contamination of the primary container occurs, the primary container shall be placed within a secondary container which prevents leakage during the handling, processing, storage, transport, or shipping of the specimen.

6. *Contaminated equipment*

_____ (insert name of position or person) is responsible for ensuring that equipment which has become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary unless the decontamination of the equipment is not feasible.

7. *Personal protective equipment*

a) PPE provision

_____ (insert name of position or person) is responsible for ensuring that the following provisions are met.

All personal protective equipment used at this facility will be provided without cost to employees. Personal protective equipment will be chosen based on the anticipated exposure to blood or other potentially infectious materials. The protective equipment will be considered appropriate only if it does not permit blood or other potentially infectious materials to pass through or reach the employees' clothing, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used. (Indicate how clothing will be provided to employees, eg who has responsibility for distribution. You could also list which procedures would require the protective clothing and the recommended type of protection required, this could also be listed as an appendix to this program.)

b) PPE use

_____ (insert name of position or person) shall ensure that the employee uses appropriate PPE unless the supervisor shows that employee temporarily and briefly declined to use PPE when under rare and extraordinary circumstances, it was the employee's professional judgement that in the specific instance its use would have prevented the delivery of health care or posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgment, the circumstances shall be investigated and documented to determine whether changes can be instituted to prevent such occurrences in the future.

c) PPE accessibility

_____ (insert name of position or person) shall ensure that appropriate PPE in the appropriate sizes is readily accessible at the work site or is issued without cost to employees. Hypoallergenic gloves, glove liners, powderless gloves, or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.

d) PPE cleaning, laundering, and disposal

All personal protective equipment will be cleaned, laundered, and disposed of by the employer at no cost to the employees. All repairs and replacements will be made by the employer at no cost to employees.

All garments which are penetrated by blood shall be removed immediately or as soon as feasible. All PPE will be removed prior to leaving the work area.

When PPE is removed, it shall be placed in an appropriately designated area or container for storage, washing, decontamination or disposal.

e) Gloves

Gloves shall be worn where it is reasonably anticipated that employees will have hand contact with blood, other potentially infectious materials, non-intact skin, and mucous membranes; when performing vascular access procedures and when handling or touching contaminated items or surfaces.

Disposable gloves used at this facility are not to be washed or decontaminated for re-use and are to be replaced as soon as practical when they become contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised. Utility gloves may be decontaminated for re-use provided that the integrity of the glove is not compromised. Utility gloves will be discarded if they are cracked, peeling, torn, punctured, or exhibit other signs of deterioration or when their ability to function as a barrier is compromised.

f) Eye and face protection

Masks in combination with eye protection devices, such as goggles or glasses with solid side shield, or chin length face shields, are required to be worn whenever splashes, spry platter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can reasonably be anticipated. Situations at this facility which would require such protection are as follows:

_____

_____

_____

g) Additional protection

Additional protective clothing (such as lab coats, gowns, aprons, clinic jackets, or similar outer garments) shall be worn in instances when gross contamination can reasonably be anticipated (such as autopsies and orthopedic surgery). The following situations require that such protective clothing be used:

8. *Housekeeping*

This facility will be cleaned and decontaminated according to the following schedule: (list area and schedule)

Area	Schedule	Cleaner

Decontamination will be accomplished by using the following materials: (list the materials which will be used, such as bleach solutions or EPA registered germicides)

_____

_____

_____

All contaminated work surfaces will be decontaminated after completion of procedures and immediately or as soon as feasible after any spill of blood or other potentially infectious materials, as well as the end of the work shift if the surface may have become contaminated since the last cleaning. (Employers should add in any information concerning the usage of protective coverings, such as plastic wrap which they may be using to assist in keeping surfaces free of contamination.)

All bins, pails, cans, and similar receptacles shall be inspected and decontaminated on a regularly scheduled basis (list frequency _____ and by position or person _____).

Any broken glassware which may be contaminated will not be picked up directly with the hands.

Reusable sharps that are contaminated with blood or other potentially infectious materials shall not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

9. *Regulated waste disposal*

a) Disposable sharps

Contaminated sharps shall be discarded immediately or as soon as feasible in containers that are closable, puncture resistant, leak proof on sides and bottom and labeled or color coded.

During use, containers for contaminated sharps shall be easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found (eg, laundries).

The containers shall be maintained upright throughout use and replaced routinely and not be allowed to overfill.

When moving containers of contaminated sharps from the area of use, the containers shall be closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

The container shall be placed in a secondary container if leakage of the primary container is possible. The second container shall be closeable, constructed to contain all contents and prevent leakage during handling, storage and transport, or shipping. The second container shall be labeled or color coded to identify its contents.

Reusable containers shall not be opened, emptied, or cleaned manually or in any other manner which would expose employees to the risk of percutaneous injury.

b) Other regulated waste

Other regulated waste shall be placed in containers which are closeable, constructed to contain all contents and prevent leakage of fluids during handling, storage, transportation or shipping.

The waste must be labeled or color coded and closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

Note: Disposal of all regulated waste shall be in accordance with applicable federal, state and local regulations. (The DNR is the controlling agency in Wisconsin.)

10. *Laundry procedures*

Laundry contaminated with blood or other potentially infectious materials will be handled as little as possible. Such laundry will be placed in appropriately marked (biohazard labeled, or color coded red bag) bags at the location where it was used. Such laundry will not be sorted or rinsed in the area of use.

Note: If your facility used body substance isolation or universal precautions in the handling of all soiled laundry (ie, all laundry is assumed to be contaminated) no labeling or color coding is necessary if all employees recognize the hazards associated with the handling of this material.

Laundry at this facility will be cleaned at_____.

Note: If your facility ships contaminated laundry off-site to a second facility which does not use universal precautions in the handling of all laundry, contaminated laundry must be placed in bags or containers which are labeled or color coded. One possible solution would be to include a requirement in the contract laundry scope of work requiring the laundry to use the equivalent of universal precautions.

11. *Hepatitis B vaccine and post-exposure evaluation and follow-up.*

a) General

The (insert company name) _____ shall make available the hepatitis B vaccine and vaccination series to all employees who have occupational exposure, and post exposure follow-up to employees who have had an exposure incident.

The (insert position or person) _____ shall ensure that all medical evaluations and procedures including the hepatitis B vaccine and vaccination series and post exposure follow-up, including prophylaxis are:

- made available at no cost to the employee;
- made available to the employee at a reasonable time and place;
- performed by or under the supervision of a licensed physician or by or under the supervision of another licensed health care professional; and
- provided according to the recommendations of the US Public Health Service.

All laboratory tests shall be conducted by an accredited laboratory at no cost to the employee.

b) Hepatitis B vaccination

_____ (insert name of position or person) is in charge of the hepatitis B vaccination program. (Where appropriate: We contract with _____ to provide this service.)

Hepatitis B vaccination shall be made available after the employee has received the training in occupational exposure (see information and training) and within 10 working days of initial assignment to all employees who have occupaticnal exposure unless the employee has previously received the complete hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicate for medical reasons.

Participation in a screening program shall not be a prerequisite for receiving hepatitis B vaccination.

If the employee initially declines hepatitis B vaccination but at a later date while still covered under the standard decides to accept the vaccination, the vaccination shall then be made available.

All employees who decline the hepatitis B vaccination offered shall sign the OSHA required waiver indicating their refusal.

If a routine booster dose of hepatitis B vaccine is recommended by the US Public Health Service at a future date, such booster doses shall be made available.

c) Post-exposure evaluation and follow-up

All exposure incidents shall be reported, investigated, and documented. When the employee incurs an exposure incident, it shall be reported to (list who has responsibility for investigation of exposure incidents): _____.

Following a report of an exposure incident, the exposed employee shall immediately receive a confidential medical evaluation and follow-up, including at least the following elements:

- Documentation of the route of exposure, and the circumstances under which the exposure incident occurred.
- Identification and documentation of the source individual, unless it can be established that identification is infeasible or prohibited by state or local law. (Employers may need to modify this provision in accordance with applicable local laws on this subject. Modifications should be listed here:_____).
- The source individual's blood shall be tested as soon as feasible and after consent is obtained to determine HBV and HIV status. If consent is not obtained, the (insert name of position or person) _____ shall establish that legally required consent cannot be obtained. When the source individual's consent is not required by law, the source individual's blood, if available, shall be tested and the results documented.
- When the source individual is already known to be infected with HBV or HIV, testing for the source individual's known HBV or HIV status need not be repeated.
- Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

Collection and testing of blood for HBV and HIV serological status will comply with the following:

- The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained;
- The employee will be offered the option of having their blood collected for testing of the employee's HIV and HBV serological status. The blood sample will be preserved for up to 90 days to allow the employee to decide if the blood should be tested for HIV serological status.

All employees who incur an exposure incident will be offered post-exposure evaluation and follow-up in accordance with the OSHA standard. All post exposure follow-up will be performed by (insert name of clinic, physician, department) _____.

d) Information provided to the health care professional

The (insert name of position or person) _____ shall ensure that the health care professional responsible for the employee's hepatitis B vaccination is provided with the following:

- A copy of 29 CFR 1910.1030 (while the standard outlines the confidentiality requirements of the health care professional, it might be helpful for the employer to remind that individual of these requirements).
- A written description of the exposed employee's duties as they relate to the exposure incident.
- Written documentation of the route of exposure and circumstances under which exposure occurred.
- Results of the source individuals blood testing, if available.
- All medical records relevant to the appropriate treatment of the employee including vaccination status.

e) Health care professional's written opinion

The (insert name of position or person) _____ shall obtain and provide the employee with a copy of the evaluating health care professional's written opinion within 15 days of the completion of the evaluation.

The health care professionals written opinion for HBV vaccination shall be limited to whether HBV vaccination is indicated for an employee, and if the employee has received such vaccination.

The health care professional's written opinion for post exposure follow-up shall be limited to a statement that the employee has been informed of the results of the evaluation,; and a statement that the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment. All other findings or diagnosis shall remain confidential and shall not be included in the written report.

12. *Labels and signs*

_____ (insert name of position or person) shall ensure that biohazard labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious materials, and other containers used to store, transport or ship blood or other potentially infectious materials.

The universal biohazard symbol shall be used. The label shall be fluorescent orange or orange-red.

Red bags or containers may be substituted for labels. Regulated wastes, however, must be handled in accordance with the rules and regulations of the organization having jurisdiction.

Blood products that have been released for transfusion or other clinical use are exempted from these labelling requirements.

13. Information and training

_____ (insert name of position or person) shall ensure that training is provided at the time of initial assignment to tasks where occupational exposure may occur, and that it shall be repeated within 12 months of the previous training. Training shall be tailored to the education and language level of the employee, and offered during the normal work shift. The training will be interactive and cover the following:

- A copy of the standard and an explanation of its contents.
- A discussion of the epidemiology and symptoms of blood-borne diseases.
- An explanation of the modes of transmission of blood-borne pathogens.
- An explanation of the _____ (insert company name) blood-borne pathogen exposure control plan (this program), and a method for obtaining a copy.
- The recognition of tasks that may involve exposure.
- An explanation of the use and limitations of methods to reduce exposure, for example engineering controls, work practices and personal protective equipment (PPE).
- Information on the types, use, location, removal, handling, decontamination, and disposal of PPEs.
- An explanation of the basis of selection of PPEs.
- Information on the hepatitis B vaccination, including efficacy, safety, method of administration, benefits, and that it will be offered free of charge.
- Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
- An explanation of the procedures to follow if an exposure incident occurs, including the method of reporting and medical follow-up.
- Information on the evaluation and follow-up required after an employee exposure incident.
- An explanation of the signs, labels, and color coding systems.

The person conducting the training shall be knowledgeable in the subject matter.

Employees who have received training on blood-borne pathogens in the 12 months preceding the effective date of this policy shall only receive training in provisions of the policy that were not covered.

Additional training shall be provided to employees when there are any changes of tasks or procedures affecting the employee's occupational exposure.

14. Keeping records

a) Medical records

_____ (insert name of position or person) is responsible for maintaining medical records as indicated below. These records will be kept (insert location) _____. (If you contract for post-exposure follow-up and hepatitis B vaccination evaluation, make sure that your contract language includes provisions for keeping records which are consistent with the requirements of 1910.20.)

Medical records shall be maintained in accordance with OSHA Standard 29 CFR 1910.20. These records shall be kept confidential, and must be maintained for at least the duration of employment plus 30 years. The records shall include the following:

- The name and social security number of the employee.
- A copy of the employee's HBV vaccination status, including the dates of vaccination.
- A copy of all results of examinations, medical testing, and follow-up procedures.
- A copy of the information provided to the health care professional, including a description of the employee's duties as they relate to the exposure incident, and documentation of the routes of exposure and circumstances of the exposure.

b) Training records

_____ (insert name of position or person) is responsible for maintaining the following training records. These records will be kept (insert location) _____.

Training records shall be maintained for 3 years from the date of training. The following information shall be documented:

- the dates of the training sessions;
- an outline describing the material presented;
- the names and qualifications of persons conducting the training; and
- the names and job titles of all persons attending the training sessions.

c) Availability

All employee records shall be made available to the employee in accordance with 29 CFR 1910.20.

All employee records shall be made available to the assistant secretary of labor for OSHA and the director of the National Institute for Occupational Safety and Health (NIOSH) on request.

d) Transfer of records

If this facility is closed or there is no successor employer to receive and retain the records for the prescribe period, the director of the NIOSH shall be contacted for final disposition.

15. *Evaluation and review*

_____ (insert name of position or person) is responsible for annually reviewing this program, and its effectiveness, and for updating this program as needed.

16. *Dates*

All provisions required by this standard will be implemented by: (insert date for implementation of the provisions of the standard).

17. *Outside contractors*

While the written exposure control plan does not have to address information obtained from and provided to outside contractors, you may wish to establish standard operating procedures for these situations and append them to this document.

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Yes, include my name in the *Coalition's* membership

Name _____

Address _____

City/State/Zip _____ Telephone # _____

Specialty _____

Auxiliary Member ☐ Yes ☐ No Other _____

Area of interest within Family Violence: ☐ Child Abuse ☐ Sexual Assault ☐ Domestic Violence

☐ Elder Abuse ☐ Other

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Tube feeding in Wisconsin: medicine and law in conflict

Richard S. Kane, MD, Milwaukee

THE USE OF TUBE FEEDING is routine and sound medical practice for many groups of patients. Disagreement on its use, however, can be intense when a severely demented patient loses the ability to ingest food normally. Differences in the legal, ethical, and medical aspects complicate the decision-making process. I contend that restrictive laws and policies designed to prolong life may actually cause inappropriate medical decisions which preempt possible recovery in some patients.

Oral feeding should never be withheld unless a clear medical contraindication exists, such as a bowel obstruction. Tube feeding has been characterized by the United States Supreme Court as a medical procedure.[1] The *Cruzan* decision also established that a competent adult can refuse any medical treatment including tube feeding. This refusal may be in verbal or written form while the patient is competent, and the patient may direct treatment plans which may be initiated at a time of future incapacity. In *Cruzan*, the court allowed states to demand a "clear and convincing" evidence standard in proceedings where a surrogate seeks to discontinue nutrition and hydration of a patient.

Reprint request to: Richard S. Kane, MD, 6921 N Rockledge Ave, Milwaukee, WI 53209. Copyright 1992 by the State Medical Society of Wisconsin.

In Wisconsin, there are few clear legal guidelines for withholding or withdrawing tube feeding from incompetent patients (established by the courts) or incapacitated patients (incompetency not legally established). The Power of Attorney for Health Care law allows an individual to choose whether the named health care agent may withhold or withdraw tube feeding. Recently, the Wisconsin Supreme Court decided *In the Matter of the Guardianship of L.W.* that legal guardians may direct the withdrawal of tube feeding, without prior authorization of the court, in patients in permanent vegetative states and without advance directives.

The new Wisconsin living will law is based on a belief held by many people that tube feeding may only be withheld from patients who are terminally ill. It allows for the withholding of tube feeding from people with terminal conditions or in permanent vegetative states. According to the statute, "*Terminal condition* means an incurable condition caused by injury or illness that reasonable medical judgment finds would cause death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death" (Wis Stat § 154.01(8)). "*Permanent vegetative state* (PVS) means a condition that reasonable medical judgment finds constitutes complete and irreversible cessation of all the functions of the cerebral cortex and results in a complete, chronic and irreversible cessation of all cognitive functioning and consciousness and a complete lack of behavioral responses that indicate cognitive functioning, although autonomic functions continue" (Wis Stat § 154.01(5m)).

Despite the *L.W.* decision, some incompetent and incapacitated individuals without advance directives will still present problems when oral intake is inadequate. Some people believe that a person with dysphagia associated with permanent dementia is not terminal because tube feeding may prolong his or her life for years. Therefore, the patient must be fed. Their decision is based on the prognosis of the cardiorespiratory function. Others believe such a patient to be terminally ill. Based on the prognosis of cerebral function, death of the "person" is believed to have virtually occurred, while death of the body inevitably ensues without medically administered nutrition. I believe both arguments in these severely brain diseased patients are of no help in resolving tube feeding conflict because they are disagreements of definition rather than arguments of logic.

These opinions, however, shape strong symbolic images of tube feeding. For some, the withholding of this procedure implies starving a patient to death. To others, it means the relief of pain and suffering in a hopelessly ill patient. Feeding a vegetative patient is the provision of basic, routine care in the opinion of many. To others, it represents the cruel denial of a natural death. Certainly other

Continued on next page

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symbolic meanings of the use and withholding of tube feeding exist, such as love, duty or abandonment.[2] All these varied images create a confusing backdrop for discussions concerning the use of feeding tubes.

In Wisconsin, some public prosecutors do not see dementia as a terminal illness. They interpret the legal definitions of PVS and terminal condition as excluding dementia patients who require medical assistance to ingest adequate nutrition. They remind us that if this is so, then criminal prosection against physicians who withhold or withdraw tube feeding remains a possibility, notwithstanding the immunity granted by sec 154.07(1).

Some institutions have also tried to influence tube feeding decisions by requiring tube feeding or disallowing withdrawal of it in patients with inadequate oral intake. These policies are based on religious or risk management principles. Unless such policy is made clear prior to admission, it is a violation of the patient's rights when he or she is clearly opposed to the procedure.[3]

These strict interpretations and restrictions can have life-shortening effects on some patients even though their intent is life prolonging. This is demonstrated by comparing Figures 1 and 2. Figure 1 is a tube feeding decision flow chart for patients with severe cognitive deficit with new onset of inadequate ingestion of food, whether it be due to the primary neurologic illness or the result of secondary pathology. This diagram is meant to be a general guide for the purposes of this discussion. Individual patients with unique problems may be found for whom the chart does not apply.

Medically, the first step should be an attempt to define the prognosis accurately and to improve function, if possible. This may involve a trial of tube feeding which can be withdrawn if swallowing improves adequately. If swallowing is found to be permanently impaired, establishing priority between prolongation of life and relief of pain and suffering must be done, as these two goals of medicine may be in conflict. Whichever is selected probably represents a very strong personal philosophy of the decision maker, either patient or surrogate.[4]

Tube feeding should be used if life prolongation is considered more important than relief of pain and suffering. If the definition of pain and suffering is limited only to physical discomfort, then there should be little objection to tube feeding. Some people tolerate nasogastric tubes without discomfort, and gastrostomy tubes are well tolerated by most patients.

Some people believe that patients with severe cognitive impairment suffer from the boredom, helplessness, and hopelessness of their condition. If this kind of suffering is included in the broader definition of pain and suffering, and relief of pain and suffering is of a higher priority than life prolongation, then the use of tube feeding and other life prolonging procedures would be contraindicated. Natural death is the only acceptable resolution to such permanent suffering.

When feeding tubes are not allowed to be discontinued by policy or threat of legal action, temporary trials become strongly discouraged. Figure 2 shows the resulting change in the decision making process. Many people fear prolonged existence in a vegetative or near vegetative state much more than they fear death. Whereas they might desire nutritional support while prognosis is being evaluated, they would not want it at the risk of permanent prolongation in the undesired state.

The starting point on this alternate chart assumes all efforts to orally feed have failed and time is limited. The prioritization of the two fears must be made early. Those whose greater fear is death should be technologically fed. Withholding is easier than withdrawal because it is low profile in nature. It does not have the inherent visibility that withdrawal has.[5] Therefore, many who fear a permanently helpless existence will opt to have tube feeding withheld due to the restrictions

Continued on page 238

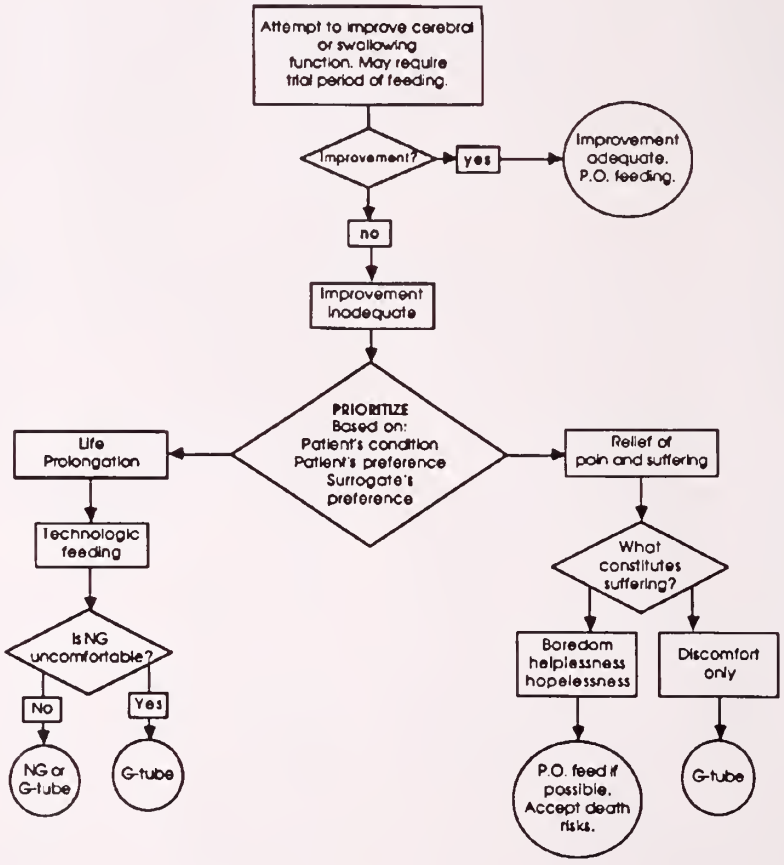

Fig 1.–Technologic feeding decision flow chart.

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Continued from page 236
on discontinuation or the fear of criminal prosection for withdrawing tube feeding.

When withholding of technological feeding occurs at the onset of an illness, it does not allow for the possibility of unexpected positive outcome. For many reasons, a large number of people will fail to leave advance directives. The result of removing options for these people who have forever lost their human cerebral functioning, and dooming them to a possibly unwanted existence, is that the opportunity for a temporary trial of tube feeding will also be lost for those who do have a chance, however small, to return to a cognitive and acceptable existence.

The legal definition of dying or terminal illness, quoted from Wis Stat § 154.01(8) in the fourth paragraph of this article, is vague. It allows for a multitude of positions as it depends on medical judgment. To help resolve existing conflict, the medical and legal communities need to establish a mutually acceptable definition of dying. A law defining dying needs to consider end stage brain disease as well as how life prolonging treatments will effect the application of this definition to individual patients.

In determining the use of life prolonging treatments, I believe severe and permanent deficits in cerebral function should be weighed more heavily than the prognosis of the other vital functions. Many people see higher brain function as the essence of human life as did Hippocrates when he wrote: "From the brain and the brain alone, arise our pleasures, joys, laughter, and jests, as well as our sorrows, pains, griefs, and tears."[6] When this human cerebral functioning is permanently gone, there is no rational reason for prolonging mere bodily existence with medical procedures except, for some patients, to follow their religious precepts.

The "slippery slope" principle is cited as a reason for requiring prolongation of such lives. This point is valid when such decisions are guided by government policy. It is too easy for governments to abuse this kind of power to the detriment of minority populations as demonstrated by history, eg Nazi Germany's use of euthanasia. This kind of abuse, however, will be avoided when decisions are based on the personal philosophies and feelings of close surrogates such as family members or close friends.

Of course, surrogates may not always consider the best interest of the patient and make truly selfish or inappropriate decisions.[7] Does that mean that the proper way to protect against inappropriate withholding of tube feeding is to force feed all end stage dementia patients and prolong their dehumanized condition? I think not. There must be a better way.

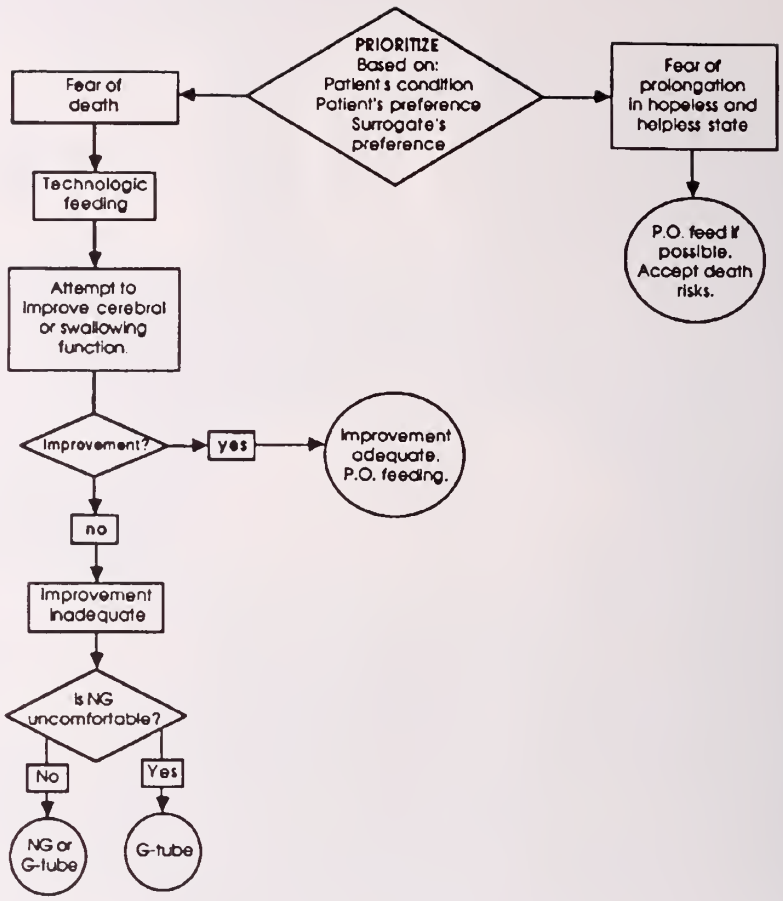

Fig 2.–Technologic feeding decision flow chart forced by not allowing feeding tubes to be discontinued after insertion.

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Public health

Ground-level ozone in Wisconsin: potential health effects

Jay Goldring, PhD, and Robert D. Morris, MD, PhD, Madison and Milwaukee

MAY IS THE BEGINNING of "ozone season" in Wisconsin. Typically, ambient ground-level ozone levels begin to increase in Wisconsin about this time, peak in July and August, and decrease through September and October.

Ozone is a colorless, odorless gas formed by the reaction of volatile organic compounds (VOC) and nitrogen oxides (NOx) with sunlight. (Ground-level ozone should not be confused with the stratospheric "ozone layer" 2 to 7 miles above the Earth's surface, which provides a shield from the sun's ultraviolet rays.) Motor vehicles account for more than half of all ozone precursors in eastern Wisconsin. The conversion of VOC or NOx to ozone occurs over a period of 6 to 12 hours. Therefore, peak levels may occur far from the original VOC or NOx sources. Indoors, ozone tends to react with surfaces and fabrics and break down. Consequently, ozone levels indoors are usually much lower than outdoor concentrations.

Healthy, exercising individuals exposed to ozone at the Federal standard of 0.12 ppm for 1 hour exhibit an average 10% drop in FEV_1. Similar decreases are also seen upon a 6 hour exposure to 0.08 ppm.[1] Patients with chronic obstructive pulmonary disease (COPD) or asthma have not shown consistent responses to acute ozone exposures. Epidemiologic studies indicate, however, that ambient ozone concentrations above 0.12 ppm may be associated with increased hospital admissions and emergency room visits for various respiratory conditions.[2,3] Ozone has also been found to increase bronchial hyperreactivity in asthmatics concurrently exposed to pollen.[4]

Effects of chronic ozone exposure are not well characterized. Epidemiologic studies suggest a decrease in lung function associated with residence in high ozone areas. Animal evidence indicates that chronic ozone exposure may contribute to the development of chronic lung diseases and bacterial infections.[2,3]

Methods

To evaluate the potential acute health effects of ozone exposure in eastern Wisconsin, we determined the yearly average number of days in each county between 1987 and 1991 during which ozone concentrations exceeded 0.12 ppm for at least one hour or 0.08 ppm for at least 6 consecutive hours. This value was calculated using the hourly ozone concentrations recorded by the Wisconsin Department of Natural Resources at monitors in each county between April 1 and October 31 of each year.

We then estimated the number of individuals in each county whose health may be affected by high ozone levels. The number working outside was defined as those reporting employment in the farming, forestry and fishing occupations in the 1980 US census. The number exercising outdoors was estimated using the percentage of individuals in four age groups reporting running, jogging or bicycling at least once a week in the past month from the 1987-1990 Wisconsin Behavioral Risk Factor Survey. We assumed that half of those working or exercising would be affected since half of the human subjects exposed to 0.12 ppm ozone in experimental chambers had noticable "shortness of breath" (Table).

Due to studies indicating that those with asthma or other chronic obstructive pulmonary disease may also be affected by high ozone levels, numbers of individuals in each county with these condi-

Continued on page 242

Populations potentially susceptible to health effects of ozone: eastern Wisconsin

County	Work outside	Exercise outside	Asthmatics	COPD	Range susceptible
Door	576	680	1,080	1,629	1,256-3,965
Kenosha	613	2,295	5,386	7,639	2,908-15,933
Kewaunee	775	460	783	1,101	1,234-3,119
Manitowoc	1,200	2,127	3,385	4,993	3,327-11,706
Milwaukee	625	28,716	39,018	56,110	29,341-124,469
Ozaukee	441	2,100	3,068	4,326	2,541-9,937
Racine	764	5,070	7,395	10,415	5,146-23,635
Sheboygan	992	2,973	4,373	6,331	3,965-14,669
Walworth	917	2,310	3,041	4,464	3,227-10,732
Washington	671	2,812	4,039	5,554	3,483-13,077
Waukesha	927	5,963	12,846	17,780	6,890-37,517
Total	8,501	55,506	84,418	120,332	64,007-268,757

See text for methods of calculation.

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Continued from page 240
tions were also included (Table). Estimates of the number of individuals with these conditions were made by multiplying the prevalence of these diseases in four age groups as estimated in the 1990 National Health Interview Survey by the county-specific population in each age group. County populations were derived from the 1990 census.

Finally, we provide a range for the number of individuals potentially affected by ozone concentrations over 0.12 ppm (Table). The minimum assumes only half of those persons working or exercising outside are affected while the maximum includes those with asthma or COPD.

Results

The Figure represents the average number of days each year between 1987 and 1991 during which ozone concentrations exceeded 0.12 ppm for 1 hour or 0.08 ppm for 6 consecutive hours. These data indicate that incidents of elevated ozone levels are most frequent in the southern counties. Also, note that the number of days during which ozone concentrations exceeded 0.08 ppm for 6 consecutive hours is approximately twice the number of days during which the federal standard was violated.

Estimates of the range of individuals in each county potentially susceptible to ozone-related respiratory impairment are presented in the Table. Our calculations indicate that between 64,007 and 286,757 people in eastern Wisconsin may be susceptible to the health effects of ozone each year. In Milwaukee County, for example, between 29,341 and 124,469 individuals may be affected on days with high ozone levels. The evidence suggests that many of these individuals may curtail their physical activity during high-ozone days. Some of these individuals may require medical attention.

Comment

Ozone levels typically encountered in eastern Wisconsin on a hot summer day may be associated with health effects ranging from mild discomfort in healthy exercising individuals to more severe respiratory problems in individuals with asthma or chronic obstructive pulmonary disease. Our calculations indicate that as many as 269,000 individuals in eastern Wisconsin may experience symptoms ranging from mild to severe shortness of breath

When the ozone level is expected to exceed the federal standard of 0.12 ppm on a given day, the Division of Health and Department of Natural Resources advise that individuals limit outdoor exercise when possible and that those with pre-existing respiratory conditions remain indoors. When ozone concentrations are expected to exceed 0.20 ppm, VOC and NOx-emitting industries are asked to voluntarily curtail their operations (ozone levels exceeded 0.20 ppm once since monitoring began). Advisories are publicized through local media and health departments.

Individuals with pre-existing respiratory conditions should use the DNR Air Quality Hotline. By calling 263-8382 in Milwaukee County and 1-800-242-4727 elsewhere, these individuals can obtain daily updates on air quality in their area and might adjust their activities.

Finally, recent studies suggest that ozone concentrations as low as 0.08 ppm for 6 hours may be associated with effects similar to those seen at 0.12 ppm for shorter periods. Days during which the concentration exceeds 0.08 ppm for 6 consecutive hours are more common in eastern Wisconsin than those during which the standard is exceeded. Patients with pre-existing respiratory conditions might be advised to curtail physical activity on these days as well.

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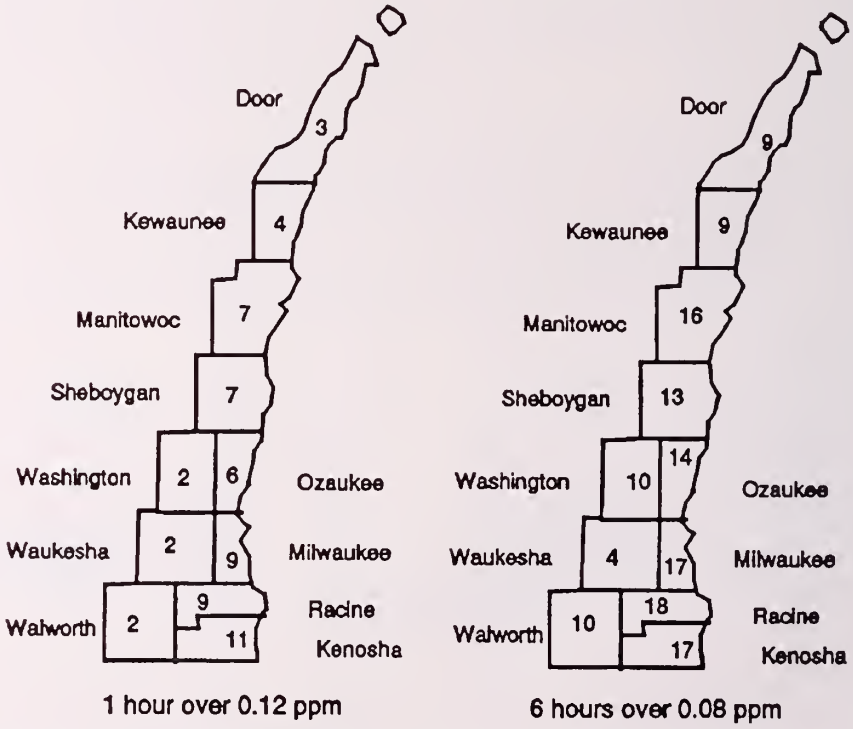

Number of days in eastern Wisconsin with high ozone levels, 1987-1991 average.

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‡ In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Please see brief summary of prescribing information on following page.

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Accupril® (Quinapril Hydrochloride Tablets)

Before prescribing, please see full prescribing information. A brief summary follows.

INDICATIONS AND USAGE

ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics

In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

CONTRAINDICATIONS

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

WARNINGS

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment, antihistamines may be useful in relieving symptoms.

Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).

Hypotension: Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N=3203); this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

Fetal/Neonatal morbidity and mortality: ACE inhibitors, including ACCUPRIL, can cause fetal and neonatal morbidity and mortality when administered to pregnant women.

When ACE inhibitors have been used during the second and third trimesters of pregnancy, there have been reports of hypotension, renal failure, skull hypoplasia, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios has been associated with fetal limb contractures, craniofacial deformities, hypoplastic lung development, and intrauterine growth retardation.

Prematurity and patent ductus arteriosus have been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure or to the mother's underlying disease. It is not known whether exposure limited to the first trimester can adversely affect fetal outcome.

A patient who becomes pregnant while taking ACE inhibitors, or who takes ACE inhibitors when already pregnant, should be apprised of the potential hazard to her fetus. If she continues to receive ACE inhibitors during the second or third trimester of pregnancy, frequent ultrasound examinations should be performed to look for oligohydramnios. When oligohydramnios is found, ACE inhibitors should generally be discontinued

Infants with histories of in utero exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Hemodialysis and peritoneal dialysis have little effect on the elimination of quinapril and quinaprilat

No fetotoxic or teratogenic effects were observed in rats at quinapril doses as high as 300 mg/kg/day (180 and 30 times the maximum daily human dose when based on mg/kg and mg/m^2, respectively), despite maternal toxicity at 150 mg/kg/day Tested later in gestation and during lactation, reduced offspring body weight was seen at ≥25 mg/kg/day, and changes in renal histology (juxtaglomerular cell hypertrophy, tubular/pelvic dilation, glomerulosclerosis) were observed both in dams and offspring treated with 150 mg/kg/day Quinapril was not teratogenic in the rabbit, however, as noted with other ACE inhibitors, maternal toxicity and embryotoxicity were seen in some rabbits at quinapril doses as low as 0.5 mg/kg/day (one time the recommended human dose) and 1.0 mg/kg/day, respectively

PRECAUTIONS

General

Impaired renal function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

Evaluation of hypertensive patients should always include assessment of renal function (see DOSAGE AND ADMINISTRATION).

Hyperkalemia and potassium-sparing diuretics: In clinical trials, hyperkalemia (serum potassium ≥5.8 mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

Surgery/anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Angioedema: Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

Symptomatic hypotension: Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

Hyperkalemia: Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

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Neutropenia: Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

NOTE As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions

Concomitant diuretic therapy: As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

Agents increasing serum potassium: Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

Tetracycline and other drugs that interact with magnesium: Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

Lithium: Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

Other agents: Drug interaction studies of ACCUPRIL with other agents showed:

- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril coadministration twice-daily
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly

Carcinogenesis, Mutagenesis, Impairment of Fertility

Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3.8 to 10 times the maximum human daily dose when based on a mg/m^2 basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilat were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro chromosome* aberration with V79 cultured lung cells, and in an *in vivo* cytogenetic study with rat bone marrow There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m^2, respectively).

Pregnancy

Pregnancy Category D: See WARNINGS, Fetal/Neonatal morbidity and mortality.

Nursing Mothers

It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in milk of lactating rats (5% or less of the plasma drug concentration was found in rat milk). Because many drugs are secreted in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

Geriatric Use

Elderly patients exhibited increased area under the plasma concentration time curve (AUC) and peak levels for quinaprilat compared to values observed in younger patients; this appeared to relate to decreased renal function rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

Pediatric Use

The safety and effectiveness of ACCUPRIL in children have not been established.

ADVERSE REACTIONS

ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below:

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N=1563) Incidence (Discontinuance)	Placebo (N=579) Incidence (Discontinuance)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N=4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in italics) include (listed by body system):

General: back pain, malaise

Cardiovascular: palpitation, vasodilation, tachycardia, *heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances*

Gastrointestinal: dry mouth or throat, constipation, *gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests*

Nervous/Psychiatric: somnolence, vertigo, syncope, *nervousness, depression*

Integumentary: increased sweating, pruritus, *exfoliative dermatitis, photosensitivity reaction*

Urogenital: *acute renal failure*

Other: amblyopia, pharyngitis, sinusitis, bronchitis, *agranulocytosis, thrombocytopenia*

Angioedema: angioedema has been reported in patients receiving ACCUPRIL (0 1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately (See WARNINGS.)

Clinical Laboratory Test Findings

Hematology: (See WARNINGS)

Hyperkalemia: (See PRECAUTIONS)

Creatinine and blood urea nitrogen: Increases (>1 25 times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy

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WOJ AND ASSOCIATES

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The great master of abdominal surgery: Nicholas Senn, MD, 1844-1908

Shari Hamilton, assistant editor

Dr Horace M. Brown later described the era as the "horse and buggy days of surgery." The year was 1881 and Nicholas Senn, MD, Brown's partner, had just led a move to establish the new Milwaukee Hospital. The new institution sought to incorporate the most up-to-date methods for antiseptic surgery.

British surgeon Joseph Lister had pioneered the movement toward antiseptic surgery 11 years before back in 1870, but American surgeons in those days paid the Brit little heed. It's not that infection wasn't a concern for US physicians: surgeons consulted the weather to fix the day of operation as a northeast wind was supposed to bear erysipela germs. If the ill wind blew, no responsible surgeon would dare touch a knife.

Continued on page 247

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1. Data on file, Lilly Research Laboratories. *See accompanying page for prescribing information.*

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Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*—for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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Additional information available to the profession on request.

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Continued from page 245

Dr Lister urged use of carbolic acid (phenol) spray during surgery to help prevent infection. By 1881 some Milwaukee surgeons were using the Lister mixture.

In a 1920 address to his fellow physicians, Dr Brown recalled the apparatus used 40 years before to spray hot carbolic solution to all parts of the room. Two or three students directed sprays toward the field of operation, he said, while "the operator Dr Senn (perhaps having washed his hands before beginning the operation, perhaps not), in his ordinary clothes, his shirt sleeves rolled up to his elbows and his abdomen and front adorned with a rubber apron, with Dr William Mackie and me, his assistants, in similar costume, in the midst of the mist and odiferous fog, endeavored to accomplish our hellish purpose.

"The admiring gallery of onlookers could be dimly seen through the haze; hanging in trace-like admiration over the operating field, with the sweat from their unwashed beards and faces dripping into the opened abdomen or other wound," Brown recalled.

It soon became apparent, Dr Brown said, that the practice was in error and the spray was quickly abandoned.

With his customary energy, Dr Senn began to employ new procedures, evaluating the success of each. He became one of the first surgeons to wear boiled cotton gloves when operating.

"At once there was an almost startling improvement in results in his cases. Next he began to insist that (those in) the gallery should not approach the patients. Again improvement in the results," Dr Brown related. "Then began an effort at bacteriological examination of the skin of the patients and the hands of operator and assistant and then of salivary spray from the mouths of those about the operating table."

Within a year, the surgeons were carrying out–in some form--many of the precautions used in modern day operating suites.

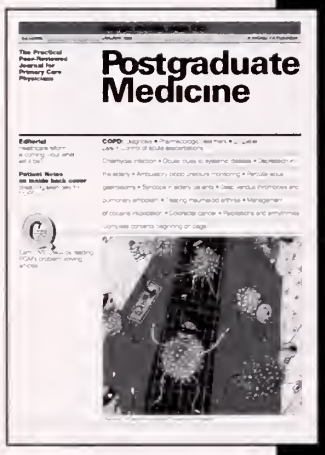
But Dr Senn, a man driven by his ambition and dedicated to his science, spent no time reflecting on his success. In his laboratory constructed under the sidewalk leading to his Milwaukee office (now marked with a plaque put up by the SMS and the Milwaukee County Historical Society), he began a long series of experiments in surgery of joints, bone implantation, brain invasion, attempts at artificial grating and nerve implantations–which provided the foundation leading to current surgical knowledge. Dr Senn was an acknowledged world leader in gastric and intestinal surgery. Using Dr Senn's methods, Dr Brown performed what is believed to be the first successful appendectomy.

Author of some 300 books, Dr Senn is remembered for his ground-breaking textbooks, *Experimental Surgery*, *Intestinal Surgery Surgical Bacteriology*, *Principles of Surgery*, and *Pathology and Surgical Treatment of Tumors*. Indulging both his passion for travel and his love of writing, Dr Senn tracked for readers his extensive travels, exploring the world from the torrid zones of innermost Africa to the arctic ice caps.

With a reputation for almost superhuman strength, Dr Senn

Continued on next page

US THEM



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Postgraduate Medicine

Nicholas Senn, MD, 1844-1908

Continued from preceding page

was known to work for three successive days, having spent the intervening nights writing in his study–without sleep or rest. "When he was in his creative moods, he was quite unaware as to whether he had changed his clothing, eaten or slept–such was the thrust of his hunger for work and for the satisfaction of his ambitions," Dr Brown observed.

Born in Switzerland, Nicholas Senn arrived in the United States at age 7, settling in with his parents on a farm near Ashford. The 1864 graduate of Fond du Lac High School taught school before beginning his study of medicine under Fond du Lac physician, Emanuel Munk, MD. In 1865, he entered the Chicago Medical College, graduating three years later with honors. With his wife, the former Arelia S. Muehlhauser, he returned to Ashford and began practicing. Five years later, he moved to Milwaukee.

In 1877 Dr Senn returned to Europe, earning another medical degree from the University of Munich. He practiced in Milwaukee until 1893, organizing the Verein Deutscher Aerzte, a society made up of German physicians of Milwaukee and American men who had studied in Germany. At age 34, he served as president of the State Medical Society of Wisconsin for 1878-1879. During the 1870s and early 1880s, he authored frequent papers and major reports on his work. He also chaired the medical society's committee on surgery.

In fall 1879, Dr Senn and other members of the committee on medical legislation met in Milwaukee with homeopathic and

eclectic representatives to draft a bill creating a state board of medical examiners. Surprisingly, the parties quickly reached an agreement for a seven-member board. Their proposal died in the Legislature.

Internationally known as the "Great Master of Abdominal Surgery," Dr Senn's amphitheater clinics became one of the attractions of medical Chicago.

In 1897, four years after taking up permanent residence in Chicago, Dr Senn was named president of the American Medical Association. He founded the Association of Military Surgeons of the United States in 1891 and was the founder of the Association of Military Surgeons for Illinois.

Devoted to military surgery, Dr Senn served as surgeon general for Wisconsin and then for Illinois, where he instituted the practice of physician examinations for recruits and candidate medical officers. At the outbreak of the Spanish-American War, he assumed command of the camp at Springfield. He later accompanied the Sixth Army Corps to duty in Santiago, Cuba, as a ranking military surgeon in the field and on board the US hospital ship "Relief." Dr Senn also served as a military surgeon in the Russo-Japanese War and as chief surgeon of the Wisconsin National Guard.

Blessed with an exceptional oratorical ability, aided by a remarkable memory, Dr Senn became an internationally acclaimed teacher. He was elected professor of principles and practice of surgery for the Chicago College of Physicians and Surgeons. In 1888 he was made professor of principles of surgery and surgical pathology in Rush Medical College and in 1891 he became a professor of clinical surgery there. Later he taught military surgery at the University of Chicago and surgery at the Chicago Policlinic.

His membership in medical congresses and scientific societies was vast. He served as a delegate to four international medical congresses and was a member of the Royal Medical Society of Budapest, Swedish Medical Society, American Surgical Society, Japanese Red Cross, American Red Cross and an honorary member of numerous other societies.

Among his generous contributions, he endowed two rooms at Chicago's St Joseph's Hospital and presented the Senn Clinical Building to Rush Medical College.

Dr Senn died at age 64 on Jan 2, 1908, in Chicago, of a chronic interstitial myocarditis of two years duration, by some accounts precipitated by ascending a South American mountain to the elevation of 16,000 feet.[15pth]

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

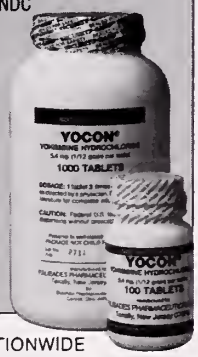
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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A glimpse into our past

Richard D. Sautter, MD, medical editor

51 years ago

Is it any different now? In his paper on mental hygiene, publishing in the *WMJ*, Dr John Flavill found fault with the public schools' system of discipline. Noting that the schools employed a system of many rules that required children to report their own infractions without reporting any "extenuating circumstances," Dr Flavill wrote that "the child knows it is not fair, and he mentally and morally revolts.... long before the years of school life are past, will begin slight prevarications, which is the highway to lying. The whole system may be fairly characterized as an ingeniously devised scheme to make liars of us all." What Dr Flavill probably did not know was that this was a training ground for future politicians and, quite unfortunately for us all, successful politicians.

Early attempts at reform failed. The SMS and the Douglas County Medical Society experimented with a "plan for prepaid sickness care which assured subscribers to the plan complete and unlimited medical care from their family physician through the payment of monthly dues varying from $1.50 to $2.90." Able to secure only 295 subscribers, the plan was discontinued. It would be interesting to see the fee schedule and what benefits were withheld.

A loss for the SMS. Jesse George Crownhart, the SMS full-time secretary, died unexpectedly on June 5. As a man, he was known as an idealist and a philosopher; as SMS secretary, he was revered for his honesty and dedication. Among his accomplishments were a monumental first-hand study of European socialized medicine and a public education campaign that finally motivated the Legislature to address the problems of quackery in Wisconsin. George's brother Charles Crownhart was eventually named successor.

101 years ago

Almost enough to draw a blush. The annual meeting was held in Madison, and the mayor welcomed the SMS members with what an uncharitable mind might interpret as hyperbole: "...in almost every century the most learned and gifted of mankind have devoted their lives and talents to (medicine's) study and practice.... We recognize the medical profession as filled with earnest, scholarly men, zealous for the welfare of their fellows." Where are these people now that we really need them?

One serious politician. The governor of Wisconsin addressed the SMS annual meeting and offered "a premium of $1 million to the specialist of any other man who will produce in the state of Wisconsin a cure for diphtheria." He immediately added, "Gentlemen, that is no laughing matter."

Let's not be too serious. The chair of the SMS committee arranging the annual meeting announced: "It is commonly known that members of the society come here to work and do not come here to waste any time, and it may be under some circumstances considered a little waste of time to indulge in too much entertainment... (but) we wish to set before you the opportunity, hoping it will be accepted, of taking a short ride upon the lake tomorrow evening." That doesn't sound unreasonable to me.[150th]

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Wanted: unforgettable characters

As part of the introspection and reflection that comes naturally to an organization turning 150 years old, the *Wisconsin Medical Journal* would like to feature the colorful, the admirable, and the unforgettable physicians of Wisconsin. If you know of a physician who you think may merit being featured in the *WMJ*, drop us a line telling us who and why. Or, if you prefer, write the story yourself and submit it for consideration. We can't promise to feature everyone suggested, but we'll strive for a good sampling. Write to: "Historical Profiles" *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.[150th]

Physician briefs

Joseph Bonanno, MD,* Chilton, has earned his board certification in internal medicine from the American College of Physicians. Dr Bonanno practices at the Calumet Medical Center. He earned his medical degree from the University of New Jersey and did his residency at Cornell University's Northshore University Hospital.

Daniel L. Dale, MD,* has joined the Green Bay Eye Clinic. Dr Dale studied at the St Louis University School of Medicine prior to graduating from the Vanderbilt University Medical School in Nashville. He interned at Naval Regional Medical Center in Oakland, Calif, and completed a residency in ophthalmology at Bethesda Naval Hospital in Maryland and a fellowship in ophthalmic plastic and reconstructive surgery at Oregon Health Sciences University in Portland. He is board certified.

Dan Fifield, MD, has been named the new medical director of the Wautoma Care Center. Dr Fifield studied medicine

Continued on next page

Photo contest corrections

Three of the honorable mention award winners in the *WMJ* physician photo contest were misidentified in the April issue (*Wis Med J.* 1992;91(4):196-197). The photos by Dr Hans P. Anderson, of La Crosse, and Dr A.M. Richter, of Waukesha, were transposed; credit is correctly given below. Dr Al Fisher, of Oshkosh, was mistakenly identified as being from La Crosse. The *WMJ* regrets the errors.[150th]

Honorable mention: Untitled by A.M. Richter, MD, of Waukesha.

Honorable mention: Untitled by Hans P. Anderson, MD, of La Crosse.

Continued from preceding page
in Guadalajara, Mexico, and at the State University of New York. He joined the Wild Rose/Waushara Doctors Clinics in 1989.

Thomas D. France, MD, of Madison, was elected president of the joint commission on allied health personnel in ophthalmology (JCAHPO) at the commission's annual meeting in Anaheim, Calif. Dr France has been vice president of JCAHPO for the past 2 years. He is a professor and director of pediatric ophthalmology and strabismus at the University of Wisconsin medical school. He represents the American Ophthalmological Society on JCAHPO.

Joseph Geenen, MD,* has received the 1992 Distinguished Citizen Award from the Racine Republican Party. He is president of Gastroenterology Consultants, Ltd; medical director of St Luke's Hospital's Digestive Disease Center, Racine; medical director of the Digestive Disease Center at Trinity Hospital, Cudahy; staff physician at St Luke's Hospital in Milwaukee; and professor of medicine at the Medical College of Wisconsin.

Thomas L. Holbrook, MD,* has joined Kettle Moraine Hospital in Oconomowoc Lake as medical director and chief of staff. Dr Holbrook has worked in addictive disease medicine for the past 18 years in Waukesha County.

Paul Jacobs, MD,* has been named medical director of the Sports Medicine Institute of Sinai Samaritan Medical Center, Milwaukee. Dr Jacobs, team physician for the Milwaukee Brewers for nearly 20 years, is an orthopedic surgeon practicing in the Milwaukee Orthopaedic Group in Mequon.

Kenneth Jensen, MD, has been named to a third term as president of the medical staff of St Mary's Hospital-Ozaukee, Port Washington. Dr Jensen practices internal medicine at Milwaukee Medical Clinic in the Port Washington and Grafton offices.

WMJ editor leads state writer's group

Russell King, editor of the *WMJ* and SMS manager of communications and publications, has been elected president of the Council for Wisconsin Writers, Inc. The nonprofit council works to promote public awareness of Wisconsin's continuing literary heritage and to encourage literary endeavors through an awards program for Wisconsin writers. King will serve a 3-year term and be eligible for reelection.

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

January 1992

* Banaszak, Edward F., Milwaukee
* Bemmann, Kathryn M., Waukesha
* Billings, Kenneth J., Marshfield
* Bloom, Thomas D., Milwaukee
* Buechel, Richard L., Wausau
* Camilleri, Bruce H., Whitefish Bay
* Christenson, Brian C., Fond du Lac
* Davidoff, Donna D., Mequon
* Davidson, James R., Monroe
* Dernlan, Robert L., Manitowoc
* Diancin, Renato C., Beaver dam
Doty, John W., Ashland
Douglas, Eustace F., Kenosha
* Flickinger, Rogert R., Waukesha
Foster, Paul A., Milwaukee
* Frase, Louis H., Eau claire
* Garcia, Arthur F., Thiensville
* Hankey, Terry L., Waupaca
* Hankwitz, Paul E., Milwaukee
* Hart, Clarence R., Lake Geneva
* Johnson, Jennifer H., Whitefish Bay
Kempton, Leo V., Solon Springs
* Keppel, Christina C., Milwaukee
* Kraus, Bruce A., Columbus
* Lois, Pamela V., Sheboygan
* Loria, Loyda O., Winneconne
Mueller, Wade M., Milwaukee
Pattison, Christine Z., Milwaukee
* Peschke, Scott R., Plymouth
* Pierce-Ruhland, Richard A., Racine
* Pollard, Randle E., Milwaukee
* Sankaran, Ramakrishan, Friendship
* Seno, Louis S.,Milwaukee
* Shaffer, Katherine A.H., Wauwatosa
* Stankevych, Anatol J., Green Bay
* Start, Armond H., Madison
* Stiehl, James B., Milwaukee
* Tibbetts, Palmer G., Milwaukee
* Willis, Robert T., Sheboygan
* Wilson, Janet A., Wisconsin Rapids
* Ziegler, John M., Janesville

February 1992

* Desch, Charles A., Waukesha
Driscoll, Thomas P., Milwaukee
* Edland, Robert W., La Crosse
Gunsolly, Brent L., Schofield
Heimler, Ruth, Milwaukee
* Huiras, Christopher M., La Crosse
* Kobelt, Carl C., Manitowoc
Kreuser, Stephen R., Washburn
* Lleva, Florentino E., Arcadia
* Lochen, Gregory R., Waukesha
Lustig, Robert H., Madison
* Martin, John E., Green Bay
* McConnell, Mark E., La Crosse
* McWey, Patrick J., Wauwatosa
* Mir, Ali Akbar, Two Rivers
Pengtovong, Lerthai, Fond du Lac
* Pulito, Frank J., Milwaukee
* Tibbetts, Palmer G., Milwaukee
* Zondlo, Joseph G., Green Bay

Carolyn A. Keever, MD, a specialist in the effects of bone marrow transplantation on the immune system, has been appointed research assistant professor of medicine at the Medical College of Wisconsin. Prior to joining MCW, Dr Keever was an assistant professor of medicine at Ohio State University.

Paul McMillan, MD, and Christopher Tashjian, MD, are the newest additions to the River Falls Medical Clinic. Both physicians specialize in family practice. Dr McMillan graduated from the Michigan State College of Human Medicine and is in the final year of a residency at the Mid-Michigan Regional Medical Center in Midland, Mich. His residency will be completed in June. Dr Tashjian received his medical degree from the University of Minnesota School of Medicine. He has been a family practice physician at the Canby (Minn) Medical Clinic since 1988.

Reynold M. Nesemann, MD,* who has practiced medicine in Kewaunee for 48 years, is the recipient of the University of Wisconsin Medical Alumni Association's Ralph Hawley Distinguished Service Award for outstanding service to his community and patients.

Dan Oppenheim, MD,* has joined Lake Geneva Medical Center and Badger Medical Center of Delevan as a pediatric specialist. Born and raised in Israel, Dr Oppenheim received his medical degree from Hebrew University in Jerusalem. He completed his training in Israel and is board certified. Dr Oppenheim's training also included a residency at Nassau Hospital, in Mineol, NY, and a fellowship in the ambulatory pediatrics at Nassau County Medical Center in East Meadow, NY. He is also an assistant clinical professor for the University of Wisconsin Medical School's Department of Pediatrics. Prior to moving to Elkhorn, Dr Oppenheim resided in Fond du Lac.

Glenn A. Smith, MD,* and Peter Franta, MD,* will join the Two Rivers Clinic, Ltd, on Sept 1. Dr Smith, a Stevens Point native, earned his medical degree from

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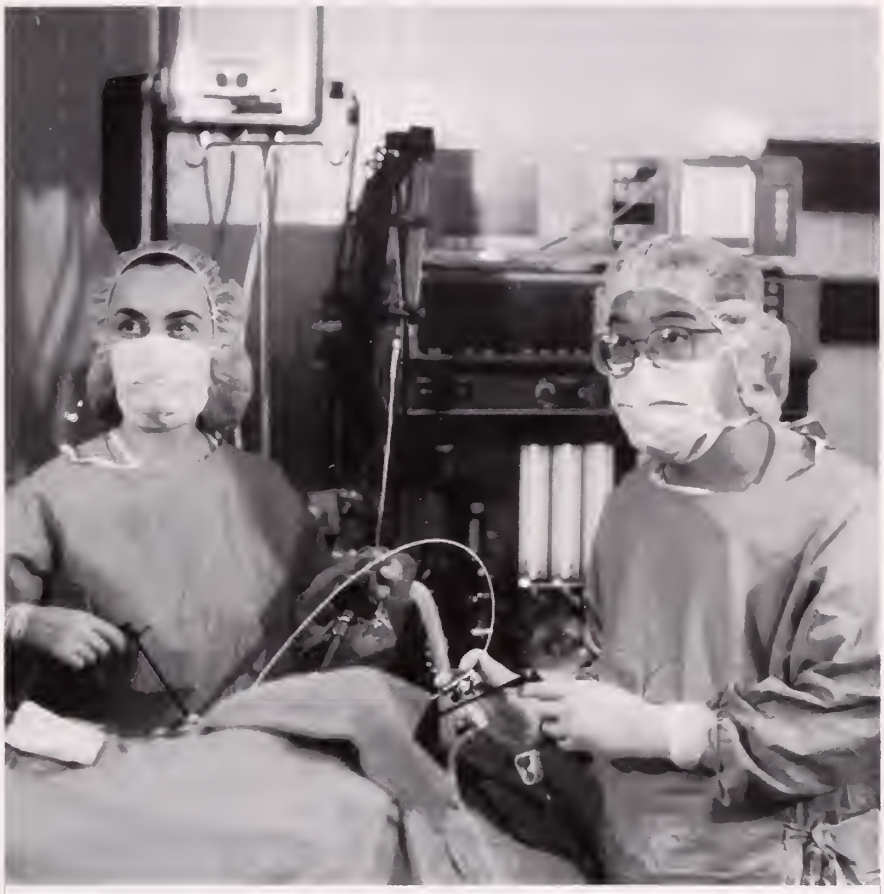

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Continued from preceding page
the University of Wisconsin Medical School in 1989. He is in his final year of residency at St Francis-Mayo Family Practice Residency Program in La Crosse. Dr Franta graduated from the University of Minnesota Medical School in 1989 and also is in his final year of family practice residency in La Crosse.

Dan Stormont, MD,* an orthopedic surgeon and member of Monroe Orthopedic Clinic, served on the faculty for the Medical College of Wisconsin Department of Orthopedic Surgery's recent annual hip and knee course. In a hands-on workshop in Aspen, Colo, Dr Stormont instructed more than 60 orthopedic surgeons on the latest techniques for total knee replacement.

Richard M. Webb, MD,* has moved his practice to his hometown of Delevan. A board-certified psychiatrist, Dr Webb is on staff at Mercy Hospital in Janesville, the Lakeside Medical Center in Elkhorn, and Parkside Lodge in Wisconsin at Janesville and Beloit. He has practice in Lake Geneva for nearly 5 years.

Obituaries

George C. Bares, MD, 64, of West Bend, died Feb 9, 1992, in West Bend. Dr Bares was born June 23, 1927, in Kenosha, and graduated from the Marquette University School of Medicine in 1954. His pathology residency was completed at Milwaukee Lutheran Hospital. Dr Bares was director of pathology and of nuclear medicine at St Joseph's Community Hospital, in West Bend, until his retirement in 1989. He was a member of the Wisconsin Society of Pathology, College of American Pathologists, American Society of Clinical Pathologists, the Washington County Medical Society, and the SMS. Surviving are his widow, Alice; one son, George A., of Wauwatosa; and three daughters, Maribeth Gensler, of West Bend, Barbara Connelly, of West Bend, and Kathryn Candela, of Middleton.

Frederic M. Blodgett, Sr, MD, 71, of Brookfield, died March 12, 1992, in Milwaukee. A nationally known pediatrician, Dr Blodgett graduated from Yale University School of Medicine and served his internship and residency at Massachusetts General Hospital. Dr Blodgett joined the Medical College of Wisconsin faculty in 1967, was a professor emeritus of pediatrics and served as chair of the department of pediatrics from 1978 to 1983. In 1984, the American Academy of Pediatrics honored him with its Job Lewis Smith Award for his outstanding service to the children of America with his work on lead poisoning identification and prevention. In 1986, the Medical College honored him with its Distinguished Service Award, the highest honor given its faculty. Surviving are his widow, Phyllis; four daughters, Mary Mitchell, of Bowie, Md, Martha Pedrick, of Clearwater, Fla, Margaret Miller, of Milwaukee, Miriam Tatum, of Derby Line, Vt; and a son, Frederic M., of Brookfield.

Aaron Bohrod, 84, prominent Madison artist, died April 3, 1992, in Madison. He

County society news

Fond du Lac. Elected to membership in the Fond du Lac County Medical Society are Timothy Wells, MD, and Victor Lerch, MD.

La Crosse. At the March meeting of the society, Michael Dolan, MD, was accepted to membership. Jack M. Lockhart, MD, discussed the resolution requesting creation of a speciality section for thoracic medicine. Recommendations of the Ad Hoc Committee on the Bylaws of the SMS were presented and discussed.

Marathon. Steven Nichols, MD, was accepted to membership at the March meeting of the society.

Oneida-Vilas. Sixteen members were present at the March meeting of the society. Guest speaker Kenneth Miller, MD, spoke on cessation of smoking. Martin Klabacha, MD, and Thomas Gobert, MD, were accepted to membership.

Ozaukee. George Frommel, MD, has been accepted to membership in the society.

Pierce-St Croix. At the February meeting of the society, Warren Abell, MD, was accepted to membership in the society.

Racine. At the March meeting of the society, David M. Feldman, MD, was accepted to membership in the society.

Waukesha. Joseph H. Luna, MD, of New Berlin, recently was elected to membership of the society.

was born Nov 21, 1907, in Chicago, and was a graduate of the Art Institute of Chicago, and the Art Students League of New York. Bohrod was an artist war correspondent during World War II for *Life* magazine, and from 1948 until 1972, was the University of Wisconsin-Madison Artist in Residence. He was commissioned by Eli Lilly & Company to illustrate the art of science of medicine. Many of his paintings are displayed in the SMS headquarters in Madison and at the Ft Crawford Medical Museum in Prairie du Chien. His paintings also have been used as the cover art of the *WMJ*. Surviving are his widow, Ruth; sons Mark, of Corvallis, Ore, and Neil, of Madison; and daughter Georgi Rothe, of Carlsbad, Calif.

Watson B. Larkin, MD, 78, formerly of Marshfield, died March 21, 1992 in Pensacola, Fla. Born July 17, 1913, in Guthrie, Okla, Dr Larkin graduated from the University of Tennessee Medical School and served his internship at Denver General Hospital in Colorado He was a veteran of World War II and the Korean War. He completed his residency in otolaryngology at Barnes Hospital in St Louis. Dr Larkin was associated with the Marshfield Clinic from 1956 to 1964 and moved to Eau Claire where he practiced until 1975. He relocated in Tennessee where he was on the staff at the VA Hospital in Johnson City. He retired from medicine in 1988. Surviving are his widow, Ingrid; three sons, Bright, of Hickory, NC, Michael, of Minneapolis, and Patrick, of Cincinnati; two daughters, Dolly, of Anchorage, Alaska, and Sandra Zais, of Lakeland, Fla.

Frederick W. Madison, MD, 92, of Milwaukee, died April 2, 1992, Santa Fe, NM. Dr Madison was born Dec 22, 1899, in Mazomanie and graduated from Columbia University Medical School. His internship and residency were completed at Philadelphia General Hospital. Certified in internal medicine, he was on the medical staffs of Milwaukee County General, Columbia, and Milwaukee hospitals. He practiced in Milwaukee for 62 years, was chief of staff at Columbia Hospital from 1942

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Continued from preceding page
to 1951, and was one of the founders of the Blood Center of Southeastern Wisconsin. He was a professor at the Medical College of Wisconsin for more than 50 years and received a distinguished service award from MCW in 1980. In 1966 he was given the University of Wisconsin Medical Alumni Citation. He was a member of the Milwaukee Surgical Society, the American Academy of Internal Medicine, the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are three children: Nancy Hayes, of Milwaukee, Sarah Lawless, of Fairfax, Va, and Frederick, of Sauk City.

Earl W. Niles, MD, 78, of Elm Grove, died Feb 26, 1992, in Elm Grove. Dr Niles was born May 3, 1913, in Milwaukee. He graduated from Marquette University School of Medicine. He was the retired chief of staff of the department of neurology of the Veterans Administration Hospital in Wood. Surviving are his widow, Harriet; four daughters, Kathy Drummond, of St Louis, Mo, Mary Fleming, of Glen Ellyn, Ill, Ginger, of Wheeling, Ill, and Chris, of Dallas.

Robert L. Waffle, MD, 84, of Fond du Lac, died March 23, 1992, in Fond du Lac. Dr Waffle was born June 7, 1907, in Fond du Lac, and graduated from the University of Wisconsin Medical School-Madison, in 1932. His internship was completed at Lutheran Hospital in La Crosse. Dr Waffle served in the US Army during World War II. After his tour of duty, Dr Waffle returned to Fond du Lac, resumed his medical practice, and also served as the anesthesiologist at St Agnes Hospital. He also was the medical director of Maple Manor Nursing Home, Care Center Nursing Home, Fond du Lac Lutheran Home and Villa Loretto Nursing Home in Mount Calvary. He was a member of the American Academy of Family Physicians, the American Heart Association, University of Wisconsin Medical Alumni Association, Fond du Lac County Medical Society, the SMS, and the AMA. Surviving is his brother, Nathan L. Waffle, of Hinsdale, Ill.

Edward Bruce Wohlwend, MD, 62, of Beaver Dam, died March 13, 1992, in Hilton Head Island, SC. Dr Wohlwend was born Feb 1, 1930, in Bisbee, Ariz, and graduated from the University of Iowa School of Medicine. His internship was served at St Benedict in Ogden, Utah, and his residency completed at the VA Hospital in Iowa City. He was board-certified in pathological anatomy and clinical pathology, held teaching appointments at St Joseph School of Medical Technology and at Waupun Memorial Hospital School of Certified Laboratory Assistants. He was a member of the medical staffs at: Beaver Dam Community Hospital; Waupun Memorial Hospital; Watertown Memorial Hospital; Hartford Hospital; Divine Savior Hospital, in Portage; Ripon Memorial Hospital; St Joseph's Memorial Hospital, in Hillsboro; Cuba City Hospital and Medical Center; Memorial Hospital, in Boscobel; and Wautoma Memorial Hospital. He was a member of the American Society of Clinical Pathology, American College of Pathology, Dodge County Medical Society, the SMS, and the AMA. Surviving are his widow, Mary Margaret; four daughters, Leslie Skyms, of the Netherlands, Lillian Armstrong, of Des Moines, Helyn Hollenbeck, of San Diego, and Melissa Wohlwend, of Eau Claire; two sons, Todd, of Germany, David, of Los Gatos, Calif; step-children, Fred Miller, of Columbus, Ohio, Michael Miller, of Beaver Dam, and Mary Liz Dawes, of Whitefish Bay.[150th]

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.[150th]

There are no small victories in the fight against heart disease.

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Madison, Wisconsin. Positions available: family practice, locum tenens (full time). Excellent salary, benefits, lifestyle. Contact Linda McLeod, Professional Staff Coordinator, Group Health Cooperative, 1 South Park St, Madison WI 53715; ph 608-251-4156. GHC is an equal opportunity/affirmative action employer. 5/92

Physician wanted in a rural practice opportunity with four other physicians. The clinic is adjacent to the Wild Rose Community Hospital. Both clinic and hospital have a strong common interest in providing quality care. We would appreciate an opportunity to meet with you and discuss matters of compensation, benefits, etc. Please contact: Dan H. Fifield, MD, PO Box 314, Wild Rose, WI 54984. 5-8/92

Radiologist. Established radiology group in independent practice is seeking two additional radiologists for growing practice in central Wisconsin. All imaging modalities. Competitive first year salary with full partner status available second year. Full benefits. Excellent schools, recreation and quality of life. Contact David E. Enerson, MD, 900 Illinois Ave, Stevens Point, WI 54481; 715-346-5140 or Andrew M. Lucas, MD, 410 Dewey St, Wisconsin Rapids, WI 54495-8080p 715-423-6060. 5/92

Iowa! Internists. Come grow with us! Sixty-five physician, multi-specialty clinic with physician-owned HMO needs four BC/BE internists to join 12. Above average income potential, excellent call schedule, friendly, family lifestyle on the Mississippi river. Just a stone's throw from beautiful southwestern Wisconsin. Excellent educational, cultural, and recreational opportunities. Call or write Denis Albright, Director of Physicians Recruiting, Medical Associates Clinic, PC, 1000 Langworthy, Dubuque, IA 52001; ph 319-589-9981. 5-7/92

Pediatrics, general surgery, family practice - Wisconsin. single specialty groups seek B/E or B/C physicians for partnership in exceptional south central community. shared call, fully equipped and staffed office, very competitive guaranteed salary, and comprehensive benefit package. For information on this and other opportunities in the Upper Midwest, send CV to: Mary Jo Cordes, President, MDsearch, PO Box 21507, St Paul, MN 55121; or call collect 612-454-7291 or FAX 612-454-7277. 5-8/92

Family doctor to serve Omro, eight miles west of Oshkosh. Modern well equipped facility available to buy. Financial assistance available. Large medical facility available within 10 miles. Contact Coldwell Banker Schwab Realty Ltd, ph 414-233-4184. 5/92

Established Fox River Valley group seeking fourth BC/BE internist. Opportunity offers high earning potential with competitive benefits package, 5-way call and recently constructed modern offices adjacent to hospital. Many recreational and cultural amenities, excellent schools and universities, low crime rate, progressive and growing economy. Contact Bob Matuszak, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; ph 800-338-7107. 5-6/92

Family practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr Paul Hayes' office 906-563-9255 or Dr William Gladstone's home 906-563-8743. Anderson Memorial Hospital, Main Street, Norway, Michigan 49870; ph 906-563-9243. 5/92

Ideal internal medicine practice. Excellent opportunity for BC/BE internist to establish a prosperous practice. Progressive 107-bed community hospital with a medical staff of 45 physicians and a service area population of over 45,000. Vibrant northern Michigan community with all summer and winter recreational activities. Salary guarantee of $110,000 with excellent benefits. Send CV or contact: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Ave, Iron Mountain, Michigan 49801; ph 800-323-8856. 5/92

Immediate opening. One general practitioner and one psychiatrist at a 230 bed acute treatment psychiatric hospital, JCAHO approved, Medicare certified, affiliated with the University of Iowa Medical College. **Forty-hour work week. No night or weekend on call.** Situated in picturesque northeast Iowa near large cities with cultural advantages. Ideal for family living. Golf club, hunting and fishing area, good schools, etc. Salary to $101,316.80. State law protects employees against malpractice. State pension plan. Unique deferred annuity plan. Generous sick leave and vacation. Write or call collect: B.J. Dave, MD, Superintendent, Mental Health Institute, Independence, Iowa 50644; ph 319-334-2583. 5-10/92

Board certified general surgeon. ACLS,ATLS seeks emergency room or urgent care position in SE Wisconsin area. Available July 1992. Please respond to Dept 634 in care of the Journal. 5-6/92

Staff psychiatrist. Medium-size smoke-free environment medical center offers primary and extended care to a large area of west central Wisconsin. Full range of psychiatric services include admissions (acute), geriatric, long-term care, out-patient, PTSD, and alcohol. Salary range to $119,500, depending on qualifications and board certification. Excellent benefits package includes malpractice protection, 30 days paid vacation, and annuity plan. Relocation expenses. 173-acre facility includes limited on-station housing and nine hole golf course. City of 7500 in a predominantly rural area that offers affordable real estate, good schools. conveniently located on I-90/94

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midway between Milwaukee and Minneapolis. Call or write: Eugene J. Traynor, MD, Chief, Psychiatry Services (116A), VA Medical Center, 500 East Veterans St, Tomah, WI 54660; ph 1-800-252-7188. EO/AAE. 5-12/92

Emergency medicine-Wisconsin. Emergency department medical director and staff positions are available at several client hospitals in Wisconsin–Portage, Watertown, and Superior. All newer emergency departments with a wide range of specialties represented. Progressive hospitals with excellent nursing staff support. Annual ED volumes range from 8,000 to 10,000. Metropolitan areas only 45 minutes from all facilities. Fee-for-service contracts, reimbursement for Wisconsin Compensation Fund. Medical directors also offered full benefit package, administrative stipend, and participation in retirement plan after 12 months of service. For complete details on available opportunities in Wisconsin, contact Mallarry Dierkes, Spectrum Emergency Care, PO Box 419052, St Louis, MO 63141; 1-800-325-3982, ext 1029. 5-7/92

Oshkosh, Wisconsin. Single specialty groups are recruiting in orthopedic surgery, ophthalmology, child psychiatry, OB/GYN, and cardiology. Oshkosh is an attractive community of 55,000 (service area of 85,000) people located on the shores of Lake Winnebago and in the heart of Wisconsin's beautiful Fox River Valley. Competitive financial packages. Contact Christopher Kashnig, physician recruiter, Mercy Medical Center, 631 Hazel Street, Oshkosh, WI 54902; or call 800-242-5650 x2430 or 414-236-2430. 4-6/92

Family practice physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD,MBA, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 4-6/92

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Wisconsin. Fourth BC/BE obstetrician/gynecologist needed to join stable, progressive, primary-care based HMO/group practice in University town of 60,000 near Minneapolis/St Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact Stuart R. Lancer, MD, MBA, Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702; 715-836-8552. 4-6/92

Fellowship offered in addictionology for physicians interested in diagnosis and treatment of alcohol and drug abuse problems. Fellow will be involved in all aspects of alcohol and clinical dependency rehabilitation to include: **1)primary patient evaluation; 2)diagnosis; 3)treatment protocols; 4)daily rounds; 5)counseling; 6)psychiatric evaluation; 7)group therapy; 8)staffing; 9)seminars.** Stipend, $27,000, plus malpractice insurance and fringes. Interested candidates please contact Mona Owens Beck, De Paul Hospital, 4143 S. 13th St, Milwaukee, WI 53221; ph 414-281-4400, ext 565. 4-5/92

Door County, Wisconsin. BC/BE internist. Modern, 89-bed community hospital with new outpatient services addition. Competitive guaranteed salary. Incentive package. Malpractice insurance. Attractive benefits. Exceptional four seasons recreation along Lake Michigan shores. Proximity to Milwaukee/Chicago. Top-rated schools. Quality community life. Send CV to Priscilla Khoury, Physician Recruitment Coordinator, 330 South 16th Place, Sturgeon Bay, WI 54235. 3-5/92

Milwaukee area. A rapidly expanding 60-physician multi-specialty clinic, seeks BC/BE physicians in the following specialties: internal medicine, family practice, orthopedic surgery, ob/gyn, urology, dermatology, and psychiatry. Competitive salary, excellent fringe benefits. Address inquiries and CV to: Administrator, PO Box 427, Menomonee Falls, WI 53052-0427. 3-5/92

Urgent care. Busy department in 60 member multi-specialty clinic to add urgent care physician immediately. Excellent salary and benefits. Beautiful southern Wisconsin. Send CV to Dr Stan Gruhn, Riverview Clinic, 580 N. Washington St, Janesville, WI 53545. 12/91;1-5/92

Pediatricians. Do you desire to live in a community that offers opportunities for personal and professional growth; family-oriented lifestyles, quality education, a strong economy and year-round multiple recreational activities? Then make your move to Sheboygan, Wisconsin–an ideal location for building a pediatric practice. Join a young, solo pediatrician in new, multi-specialty office building next to modern 185-bed hospital. This Lake Michigan city of 50,000 is close to major metropolitan cultural and sports activities (one hour drive to Milwaukee and Green Bay). BC/BE required. Contact William L. Trager, MD, 2920 Superior Ave, Sheboygan, WI 53081; ph 414-458-3331. p5-7/92

Family practice physician needed by progressive and growing family practice group in southeast Wisconsin. Semi-rural setting in the fastest growing area of the state. Excellent sub-specialty support. Highly competitive salary offered with excellent fringe benefits. Signing bonus and relocation expenses offered. BC/BE required. Practice high quality care in excellent location. Contact David P. Imse, MD, Hartland Clinic, 123 Lawn St, Hartland, WI 53029; ph 414-367-2128. 5-7/92

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The Wausau Medical Center is seeking board certified/eligible individuals in the following specialties: dermatology, family medicine, gastroenterology, hematology/oncology, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year-round as well. Write or call collect D. K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401; ph 715-847-3254. c1tfn/91

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Internist to join two internists in active practice in scenic Upper Michigan. Medical school affiliation. Contact North Shore Internal Medicine, 2420 First Ave South, Escanaba, MI 49829; ph 906-786-1563. p11tfn/91

Internist to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, new clinic and constructing new hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. c9tfn/91

Madison, Wisconsin. Positions available: family practice & urgent care (full or part-time). Excellent salary, benefits, lifestyle. Contact Dr John Hansen, Medical Director, Group Health Cooperative, One South Park St, Madison, WI 53715; ph 608-251-4156. GHC is an equal opportunity/affirmative action employer. c5tfn/91

Milwaukee suburb. New and rapidly expanding multi-specialty full-service clinic. Attractive benefits, salary, and early partnership opportunity. Positions available in internal medicine, family practice, and pediatrics. Please send CV to Administrator, Park Crest Medical Clinic, SC, 2665 South Moorland Rd, New Berlin, WI 53151. 3tfn/91

Wisconsin. 120 physician multi-specialty clinic in the Fox River Valley of northeastern Wisconsin desires two BC/BE pediatricians to join department of 15 BC/BE pediatricians. Excellent compensation and benefit package, leading to shareholder status after two years. The community offers a superb recreational, cultural, and family environment in which to practice. For information please call or write: Howard Kidd, MD, La Salle Clinic, 411 Lincoln St, Neenah, WI 54956; ph 414-727-4276. 3tfn/91

For Sale

For sale. Old x-ray unit. Fisher 100 K.V. in good working condition. Phone 414-885-3184. 5/92

Beloit Clinic, SC, a 47-physician multi-specialty group is seeking a general surgeon, neurologist, OB/GYN, orthopaedic surgeon, physiatrist, plastic surgeon, rheumatologist, and urologist. Our clinic is located adjacent to a modern, progressive 180-bed community hospital. Guaranteed salary with incentive and excellent benefit package. Send CV to James Ruethling, Administrator, 1905 Huebbe Parkway, Beloit, WI 53511, or call 608-364-2200. 3-8/92

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May 29-30, 1992: 1st Annual Clinical Neurology and Behavioral Sciences Symposium: Focus on Geriatrics, at Landmark Inn Resort, Egg Harbor. Info: Nadine Punke, Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449; ph 1-800-782-8581, ext 5207. 3-5/92

May 30, 1992: Cytokines and Transplantation, 3rd annual Rush symposium on transplantation, at Rush-Presbyterian-St Luke's Medical Center, Chicago, Ill. Fee: $150. To register, call 312-942-6242. 3-5/92

August 5-9, 1992: 43rd Annual Meeting International Doctors in AA (IDAA) in Grant Rapids, Michigan. Registration information: Connie Hyde, 3311 Brookhill Circle, Lexington, KY 40502; ph 606-233-0000; 606-277-9379; 606-253-0864 (FAX). 3-7/92

October 15-18, 1992: 44th Annual AAFP Scientific Assembly in San Diego. Info: AAFP, 8880 Ward Pkwy, Kansas City, MO 64114; ph 816-333-9700; 816-822-0580 (FAX). g3-9/92

November 8-12, 1992: Ninety-Sixth Annual Meeting of the American Academy of Ophthalmology at Dallas Center. Contact: The American Academy of Ophthalmology, Meetings Dept, PO Box 7424, San Francisco, CA 94120-7424; ph 415-561-8500. g3-9/92

AMA

June 21-25, 1992: Annual AMA House of Delegates, Chicago.
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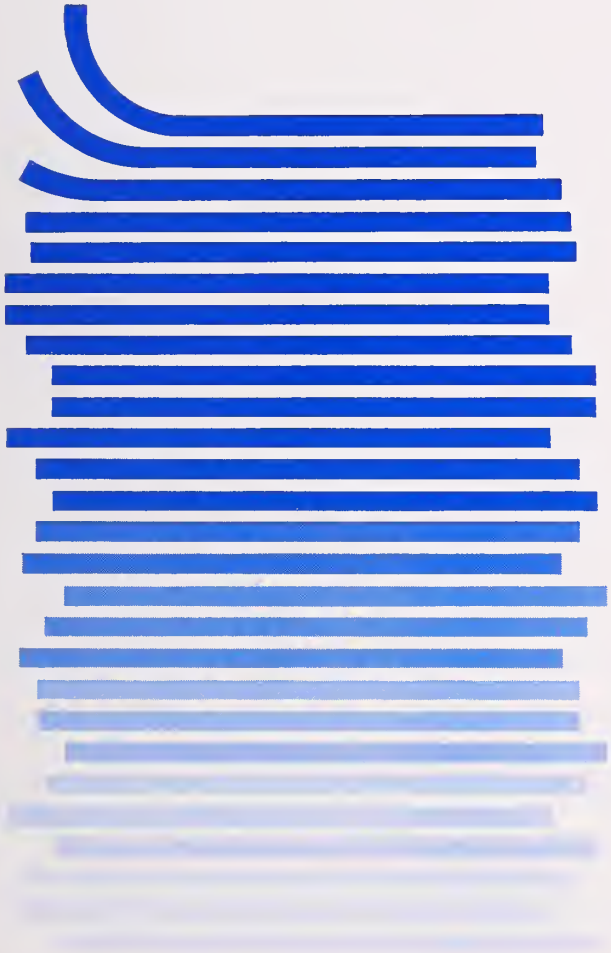

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References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus.* New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol.* 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol.* 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation.* 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology.* 1988;39:1025-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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Contents

June 1992 Vol. 91 No. 6

Opinions

263 *President's page*
Wisconsin's deadly secret—domestic violence
by William J. Listwan, MD, West Bend
266 *Secretary's report*
The balanced budget bandwagon: let's look before we leap
by Thomas L. Adams, CAE, Madison
268 *Voice of the SMS*
Medicine and the Milwaukee media
by Jonathan Temte, MD, Madison
269 *Editorial*
A favorable first impression
by Richard D. Sautter, MD, medical editor
272 *Letters*
An historic opportunity for health care reform
by Duane M. Koons, MD, Viroqua
272 Taking a stand against smoking
by Paul D. Burstein, MD, Milwaukee
273 *Soundings*
A call for a national health care funding system

Special section

279 Domestic violence: an overview
by Shari Hamilton, *assistant editor*
280 Empowering physicians to respond to domestic violence
by Kevin J. Fullin, MD, and Amanda Cosgrove, BA, Kenosha
284 The role of health care workers in responding to battered women
by Nancy Worcester, PhD, Madison
286 Wisconsin domestic abuse programs, by county
290 Resources for learning more about domestic violence

Scientific

291 A needs assessment survey of HIV-infected patients
by Debra A. Murphy, PhD; G. Richard Bahr, EdD; Jeffrey A. Kelly, PhD; Barry M. Bernstein, MD; and Michael Morgan, BS, Milwaukee
296 A multi-institutional analysis of perinatal cocaine use
by Annette O'Leary Quinn, RNC, MSN; Chris Van Mullem, RNC, BSN; Kathy Sturino, MD; and Fredrik Broekhuizen, MD, Waukesha
299 Lack of correlation between aortic calcification and bone density
by Paul J. Drinka, MD; Steven F. Bauwens, PD; and Arthur A. DeSmet, MD, Madison and Chesapeake, Va.

Socioeconomic

303 *Public health*
Increasing incidence of end stage renal disease in Wisconsin: 1982-1990
by Betsy Sleath, MS, RPh, and Patrick Remington, MD, Madison
305 Legislative wrap-up: 1991-1992

Organizational

315 A remarkable woman: Margaret Trevitt, MD, 1858-1925
by Cheri Volkert, RN, Wausau
317 A glimpse into our past
by Richard D. Sautter, MD, *medical editor*
318 Physician briefs
319 County society news
320 Obituaries

Wisconsin Medical Journal

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President's page

Wisconsin's deadly secret–domestic violence

Thank you for taking up the issue of wife abuse. It is serious. Please help our family doctors to deal with it. I ran away from an otherwise good marriage in 1979 because I didn't know what else to do. I told my family doctor and he felt helpless...

– April 1992 letter to Dr. Listwan

William J. Listwan, MD

THE MAJORITY of you are going "Oh no, boring! What does this have to do with me?" You probably feel that the issue is overly dramatized and does not apply to your practice. Certainly not in My Town, Wisconsin, or the other small communities of the state.

I am going to try to convince you that you should be more informed about domestic violence and that you need to personally become involved in this issue. Let me know whether I succeed. I will welcome your comments and criticisms, and, I hope, be able to welcome your support in this issue.

Obviously, we live in a violent society. Violence permeates our lives from the morning newspaper until the evening news. For physicians in practice, the violence may continue through the night as we tend to our patients in the emergency rooms of hospitals around Wisconsin. The Saturday morning cartoons are full of violence, many of the Saturday afternoon athletic events involve violence, and the movies that play on television and at our movie theaters are saturated with violence.

So far, we all agree. Violence is endemic in our society. But is it really a problem in the family?

The AMA has complied statistics that indicate that domestic violence leads to 28,700 emergency room visits per year, 39,000 physician visits in the office, $44 million in total annual medical costs, and 175,000 days lost from work.[1] The FBI estimates that an American woman is beaten by her partner every 15 seconds, and last year alone 6,000 Milwaukee women sought court restraining orders to protect them from abusive partners. Not insignificant figures. As a matter of fact, battering appears to be the single most frequent cause of injury to women, more common than auto accidents, muggings,

Continued on next page

Dr Listwan organizes task force on domestic violence

In keeping with his decision to focus his presidency on the issue of domestic violence, SMS President William J. Listwan, MD, has organized a special task force on domestic violence.

The task force will look at ways to increase physician awareness of domestic violence issues and propose policies for consideration by the SMS Board of Directors. Members of the task force include: Kevin Fullin, MD, a Kenosha cardiologist; Mark Chelmowski, MD, a Milwaukee internist; Richard Aronson, MD, of the state Department of Health and Social Services in Madison; Paul Steingraeber, MD, an OB-GYN from La Crosse; Larry La Crosse, MD, a physician specializing in emergency medicine; Richard Ellis, MD, a Madison pediatrician, Joanne Selkurt, MD, a Whitehall pediatrician, and Patricia Barwig, an OB-GYN from Milwaukee. Auxiliary representatives will be Fe Abellera, of Onalaska, and Leah Speltz, of Wausau.

Contined from preceding page
and rapes combined.[2]

Domestic violence can be defined as "a pattern of coersive control and terror that one person uses over another." This may involve actual physical injury, physical violence without significant injury, or psychological abuse such as verbal insults and put-downs in a systematic attempt to isolate the person from friends and family. Economic abuse can also be considered to be part of domestic abuse. It's easy to understand that if someone puts a fist through a wall next to your head, the implication is that next time it could be your head. Domestic violence does *not* have to involve actual physical abuse or injury.

Domestic violence may involve abuse of the elderly, child abuse, or abuse between partners. Yes, men can be abused in a relationship also, but approximately 95% of partner abuse that results in significant injury involves a male perpetrator and a female victim.

'The FBI estimates that an American woman is beaten by her partner every 15 seconds.'

Patients involved in abusive relationships may present to the physician's office or hospital emergency room with multiple complaints, or single complaints, that seem unrelated and do not raise the issue of physical or emotional abuse. Most of you, like me, don't feel comfortable getting involved in domestic disputes and given any reasonable excuse, will duck the issue. It's easier to treat the laceration on the hand, the shortness of breath and chest tightness, or the acute gastritis than it is to inquire into the underlying problems that lead to the symptoms.

I know I have struggled with this issue in my own practice. I certainly do not ask every one of my patients whether their spouse beats them or engages in psychological torture or economic depravation. It is easy, however, to open my mind to the possibility and to inquire–even if there are no overwhelming reasons to do so–about the status of the relationship. An open-ended question like "Are things going OK at home?" can often result in an ambivalent or equivocal answer that leads to a follow-up statement and question like "Sometimes problems like this develop because of emotional worry and stress due to a troubled relationship. Is Frank doing anything that upsets you?"

Even though I may not get a direct answer the first time around, I am implying to the patient that I am available to talk about family problems. The hope is

Continued on page 266

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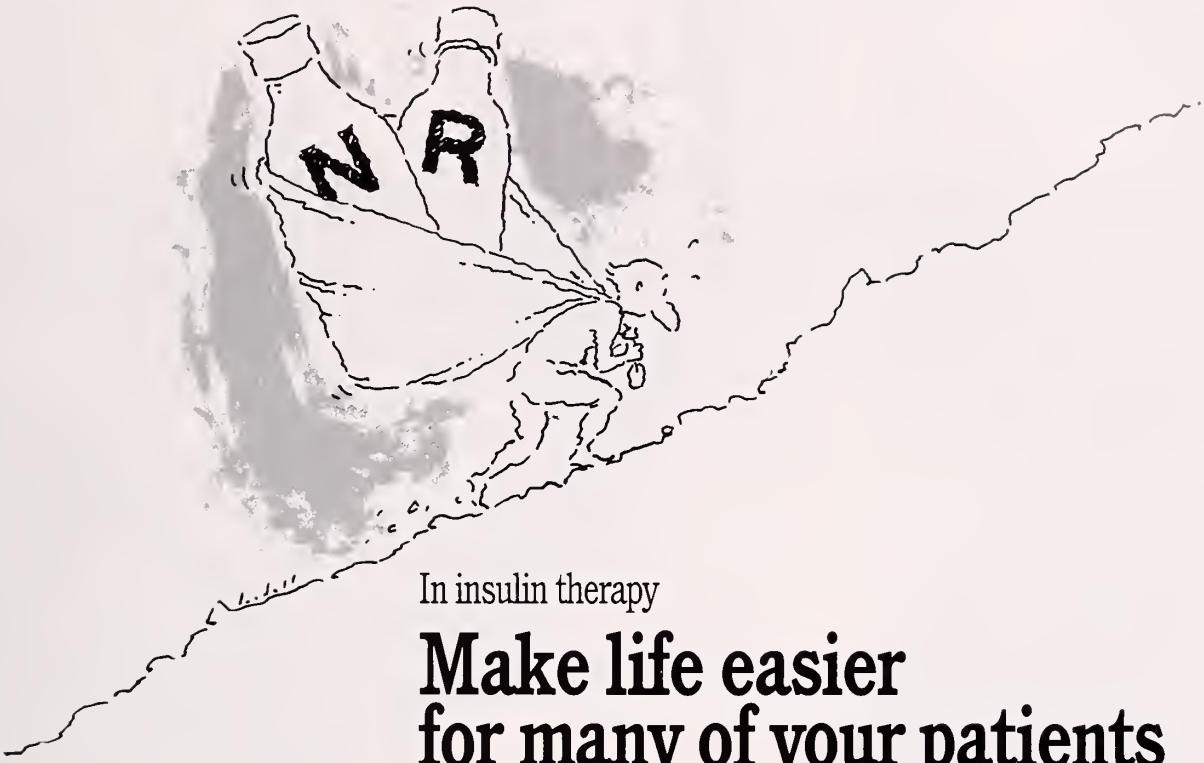

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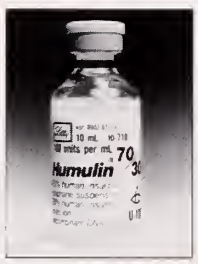

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WARNING: Any change of insulin should be made cautiously and only under medical supervision.

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Continued from page 264
that, at a future visit, if domestic violence is really a problem, my patient will feel more comfortable bringing it up and talking about it with me. It's easy to bury your head in the sand and say no problem exists. But remember, if your head is stuck in the sand you can't watch the parade go by.

The first step is recognition of the problem. The second is letting the patient know it is not her fault. Many of the people involved in an abusive relationship find all kinds of reasons to blame themselves. They feel they deserve the trauma because of some action or lack of action on their part and actually feel responsible for the physical or verbal actions directed at them. Clearly this is not true; and letting them know they are not alone, they are not to blame, and there are options available to them is part of our job.

These issues and relationships are often exceedingly complex and most primary care physicians, like myself, do not have the time or training to help these patients work through all of their options and arrive at a decision. But I can give my support to their attempts to get help, and I do need to know where to refer them.

In this edition of the *WMJ*, you will find several helpful articles on domestic violence, including an overview of the problem, a discussion of the role of health care workers, and a list of Wisconsin community shelters and other resource contacts.

I am also naming several physicians to an ad hoc committee to study ways in which we may better address this threat to our patients' health. I will keep you abreast of their progress.

Physician involvement in the problem of domestic violence is essential. As leaders in our communities, and as leaders on the health care team, we have a responsibility to educate ourselves and to implement appropriate actions in our practices. As we become involved in this issue and identify people who do need help, we will feel better about ourselves and about our profession. Our patients will realize that we really do care about their personal problems. Society will see physicians out in front on this issue exercising their leadership. Let's get ourselves educated so we can continue helping our patients.

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Secretary's report

The balanced budget bandwagon: let's look before we leap

You have probably noticed that a proposed amendment to the US Constitution to mandate a balanced federal budget is moving through Congress with very little opposition. It will very likely pass both houses, and the president has said he will sign it if it comes to him. As it stands now, the amendment would become part of the supreme law of our land two years after it is ratified by three fourths of the states–most guesses put that at 1996, at the earliest. The consequences will not be uniformly happy.

Before I go too far, let me say that I support the idea of a balanced budget amendment. I want the federal budget balanced just as I want the state budget, the city budget, the SMS budget and my own family budget balanced. It's the cynical politics and imprudent implementation that bother me. The years of fiscal irresponsibility leading up to the current budgetary crisis have made it necessary that we carefully monitor just how this new law would take effect.

First, it may not have its intended affect. A number of states have such amendments to their constitutions, and a number of them continue spending in red ink. Instead of facing the hard work of balancing the budget, the governors and legislatures of many of these states have resorted to budget gimmickry. The increase in Wisconsin's property tax credit for this year is a good example. That credit is being funded by reduced payments to municipal governments, which will force the cities to raise taxes to cover the lost state revenue. It boils down to paying for a property tax credit with higher property taxes.

Second, the amendment may create some unintended quirks in our system of checks and balances, too. For instance, the power of the purse would tend to shift from elected officials to unelected judges

Thomas L. Adams, CAE

if Congress cannot meet the requirements of the law and the judicial system is called

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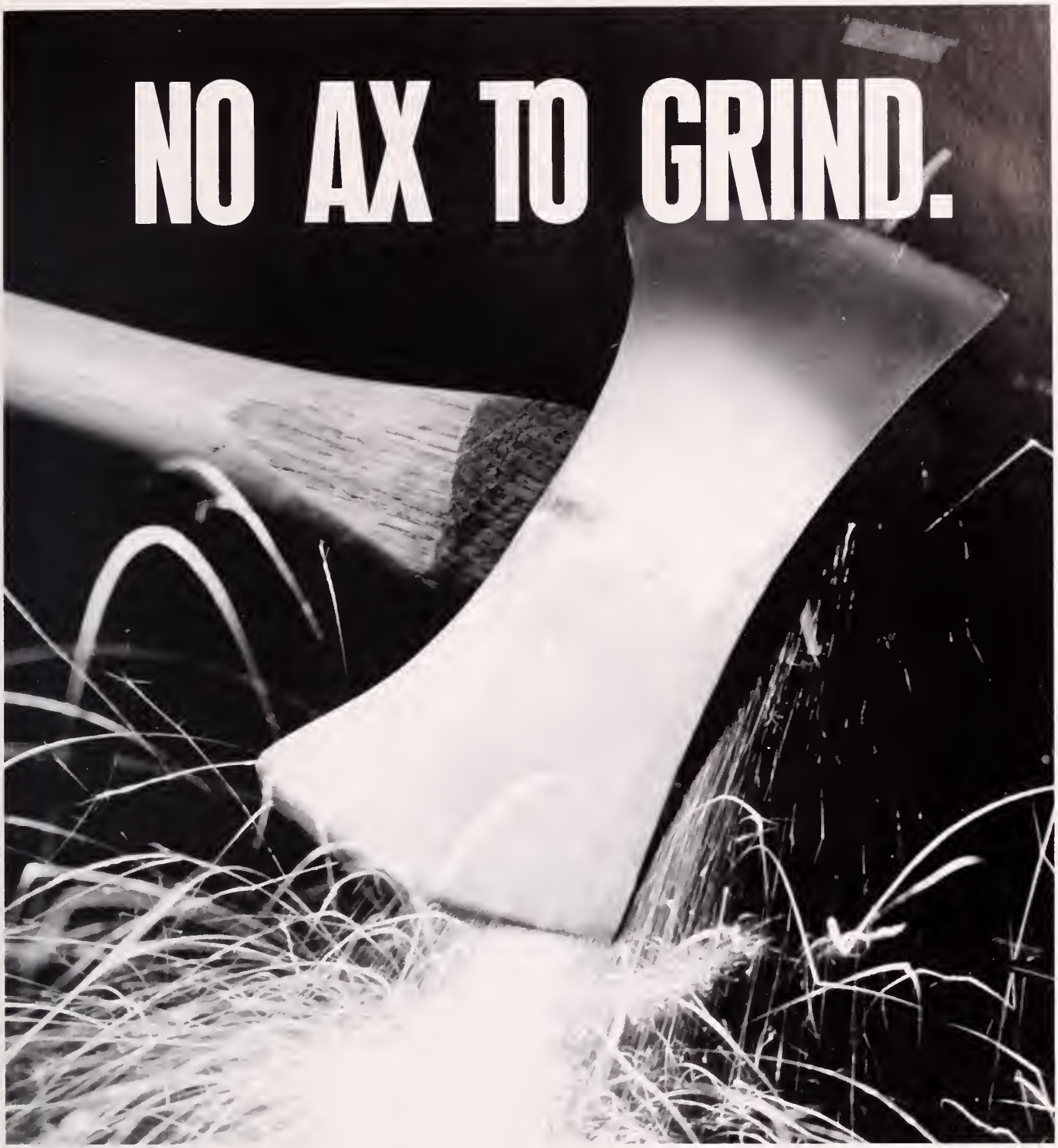

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Continued from page 266
on to enforce the law. The amendment allows an override of itself only by a three-fifths majority of both houses, which will give enormous "veto" power to a two-fifths minority. I'm certain that this is not what the founding fathers had in mind, and I doubt that it is what the American people want.

If I randomly selected 10 physicians and asked them whether a balanced-budget amendment was a good idea, I'd bet the mortgage that at least nine of them would say yes. I would then caution them to give it a little more thought. If you thought the latest cutbacks in funding of government-run health programs were painful you "ain't seen nuthin' yet." Under this amendment, those budgets will most likely go through astounding contractions. That's assuming that Washington will not dare raise taxes enough to balance the budget, which is a pretty fair assumption. It's also a fair assumption to expect that budgets of government health programs would be balanced across your shoulders.

Before we jump on this bandwagon, I think it warrants a little more thought. Is such an amendment in the best interest of the public health? Is it in the best interest of our inner city patients? Is it in the best interest of our rural patients? At first glance, it appears that the answer would be no.

Of course, the amendment can be criticized on another level: It can be seen as both an election year stunt and as a cover for the long-standing lack of will and courage in both Congress and the White House. Voting in favor of balancing the budget without rolling up your sleeves and doing the hard work and making the tough decisions that will at least move us toward a balanced budget is irresponsible at best and cynical manipulation at worst. The fact of the matter is that the Congress and president have–and always have had–the power to balance the budget. Connecticut Gov Lowell Weiker, Jr, summed it up well when he described delaying actual budget cutting while passing a balanced-budget constitutional amendment, as it would be implemented if passed today, as akin to "players on a football team rushing into the stands to yell, 'We want a touchdown!'"

Before we go too far as a nation, we need to give some serious thought to how we really want this amendment to work.[15]

Voice of the SMS

Medicine and the Milwaukee media

For the past several weeks, Wisconsin's physicians have been fielding questions from their patients about two articles produced by the Milwaukee media about physician discipline. The articles–one in the *Milwaukee Journal*, the other in *Milwaukee Magazine*–carried a similar theme: that the state Medical Examining Board fails to "protect" the public from "bad medicine" because physicians do not wish, or are afraid, to police their peers. Since there is no regulatory agency to protect the public from bad journalism, the best we can do is offer some answers to your patents' questions.

Bad journalism? Some examples: The newspaper reporter set himself up as the final arbiter of right and wrong and declared the MEB's handling of certain physicians as "lenient" and "mild." The magazine writer used at least one unnamed study, six anonymous sources–four of which were directly quoted–and a number of unsubstantiated charges. Putting aside their particular departures from objectivity, fairness and credibility, the two articles shared the flaw of incomplete reporting.

With a single telephone call–that even a student journalist would have thought to make–both reporters could have discovered that the medical community has been the chief advocate of physician discipline and quality control for nearly 150 years. In fact, for decades when Wisconsin's physicians fought for the establishment of an MEB, the end to quackery and the protection of the public, their principal opponents were legislators and the giants of the Milwaukee news media.

The first attempt to protect the public from "bad medicine" was in 1849, when the SMS began requiring candidates for membership to pass an examination of their knowledge of medical science. In the following 7 score and 3 years, physicians have fought for quality control and have met opposition from many quarters. In 1869, for example, the SMS protested a charter granted by the Legislature to a Milwaukee medical diploma mill and called for the creation of an MEB to license qualified physicians. It was not until 1897--after nearly three decades of lobbying by physicians–that an MEB was created. In fact, a casual review of SMS history turns up a good 25 official attempts by the SMS to protect the public from "bad medicine" *before* the dawn of the 20th century. These efforts covered a wide range of issues, from the labeling of medicines to the education of physicians and pharmacists.

The point is this: The article's presentation of Wisconsin's physicians' involvement in quality control is far from accurate, far from fair, and you have every right to tell your patients so.

More to the point of the articles in question, the SMS has been fighting ever since its organization for the MEB to be given more muscle, more personnel and more funding. Unfortunately, Wisconsin's elected officials have been equally persistent in resisting those efforts.

The Wisconsin tradition of physicians working to keep their own house in order was continued again in the legislative session that ended in March. The SMS Task Force on Physician Review and Discipline has, in each of the past few years, advanced to the Legislature several suggestions for reforming the MEB, and each year the Legislature has decided to do nothing.

Because state government appears to have other priorities, Wisconsin's physicians have set up a number of other methods for dealing with "bad medicine," although none of them carries the force of law. The SMS Commission on Mediation and Peer Review handles roughly 650 inquiries a year, and county medical societies, clinics and hospitals around the state conduct countless physician practice inquiries each year. Clearly, physicians are working to enhance the professionalism and competence of their profession on a number of levels.

The inarguable fact is that few professions have worked as long or as diligently to police themselves as has medicine in Wisconsin, and no other group of people has shown the strength of commitment to policing themselves as have Wisconsin's physicians. (And when the short attention span of the news media moves on to its next load of dirty laundry, Wisconsin's physicians will still be fighting the good fight.) These facts were not mentioned in the recent *Milwaukee Magazine* or *Milwaukee Journal* articles, and you have to wonder why. The omission damages the reputation of Wisconsin's medical community, of course, but it also damages the reputations of these two publications, for they have both cheated their readers.

We may be able to find some comfort in knowing that most journalists, like most physicians, carry out their professional responsibilities with both skill and care. But, since there is no licensing and regulation of journalists, we can only hope that the authors and editors of these two articles can learn from their mistakes.

Warning: check your file

The SMS Board of Directors urges all Wisconsin physicians to contact the state Medical Mediation Panels system and review the listing and contents of any case files in which they are named as a respondent. At least one physician recently discovered he was erroneously listed as a respondent by the system and, unfortunately, the incorrect filing was reported to the news media. Currently, the system has an internal method for reviewing the validity of its files, but there is no standard procedure for contacting named physicians and requesting feedback to assure the file validity and accuracy. The SMS is working with the mediation panel system to address this and other concerns. If you believe that any case in which you're named is in error, notify Randy Sproule, administrator of the Medical Mediation Panels, and copy Mark Adams, SMS corporate counsel, on any correspondence.

Contact: Wisconsin Medical Mediation Panels, Randy F. Sproule, adminstrator, 110 E Main St, Suite 320, Madison, WI 53703-3356; 608-266-7711.

Editorial

A favorable first impression

The new dean of the University of Wisconsin Medical School, Dr Laurence Marton, was a recent visitor to Marshfield, and I'd like to go on record saying that my first impression of him was quite favorable. His presentation of his work was interesting and targeted to clinicians. After the presentation, he spoke in general terms about his view of medical economics, the direction the UW Medical School must take, the practice of medicine, and management styles. He is an eloquent, accomplished communicator who has both a willingness to listen and an empathy for others–all of which will serve him and the institution well.

The review of his involvement in management was particularly interesting. He portrayed himself as being reluctant to leave his first love–science–but driven by the realization that he is required to serve a more noble need. While that is, in all probability, true, I thought I might detect a little tinkling brass in the background.

I really appreciated Dr Marton's up-

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front and straight-forward style of presenting himself and his ideas. In this world of fast talkers, the dean was a refreshing change. For example, he frankly noted that we, as people outside the UW, may not agree on everything the school does. Then, showing his diplomatic side, he urged us to discuss our differences. When it's all said, we may still disagree, but we would at least understand each other better.

Dr Marton alluded to friendly competition for patients. My own observation is that friendly competition does not exist, as I have never played a game I didn't want to win. It was his position that the medical school needs a private practice, not only to draw in the patients necessary for teaching but also to generate funds for continued research and education.

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Letters are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of letters is open to the public, but letters are limited to 500 words and subject to review by the *WMJ* editorial board. Write to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701

When addressing the practice of medicine in the medical school, the dean did not discuss what some of us feel is an unfair advantage: having tax monies to support a place of operation and the prestige of representing a medical school to attract patients. This most surely must enhance a physician's practice. He also chose not to discuss the salaries of physicians of medical schools, but I suspect they are no different than those in private practice. Additional perks enjoyed by physicians at the medical school, which I think deserve discussion because they are the envy of many of us, are the 180-day notice requirement for malpractice, the $250,000 per defendant limit on malpractice awards, and the exemption from PCF assessments. No one else I know of enjoys such protection.

It is important for physicians of the state to understand that the dean of a medical school is not a chief operating officer or a chief executive officer. He must operate in large part by persuasion. This medical school, as with most medical schools, is a collection of what was once called "fiefdoms," surrounded by moats which were sometimes filled with alligators. Crossing these moats is dangerous–even for the dean.

It is also I think important for us, as physicians of Wisconsin, to recognize the medical school as an enormous asset. While it is not as prestigious as Harvard, it is certainly among the top of the university schools of medicine.

Dr Marton was quick to point out that he recognizes the need for primary care physicians and will attempt to provide the appropriate curriculum for such training. This may be an interesting juggling act in that the level of technology and research must also be maintained.

He understands the crisis in medical economics and describes it as both a danger and an opportunity. He pointed out that doctors have a prestigious position in this society, which is not emulated in all countries. He was concerned about the "right" to a certain standard of living, which we feel we deserve as physicians. Finally, the dean is concerned that we acknowledge our obligation to provide medical care for all people of the communities we serve.

There was discussion of why the university hospital is becoming a separate corporate entity. The explanation was that, because of the imposition of rules by the Legislature, new capital purchases and renovations come so slowly that the hospital has a difficult time maintaining state-of-the-art facilities. While I know little of the legislative process, I would suspect this is an accurate statement.

Lastly, this urbane gentleman from San Francisco can certainly talk the talk, and it is my guess he will most likely walk the walk.

–Richard D. Sautter, MD
medical editor

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Letters

An historic opportunity for health care reform

To the editor: It is apparent the American public is expecting substantial change in the health care system. The electorate is particularly volatile this year due to an emerging national consensus that our dysfunctional medical insurance system contributes to our economic problems.

Organized medicine has been surprisingly silent these past few months. The RBRVS and CPT code changes have been distracting. We hold widely divergent views on reform and have varying stakes in maintaining the status quo. Unfortunately, there are powerful taboos within our profession that are stifling our ability to rationally discuss these critical issues. Consider how the phrase "socialized medicine" has been used to stigmatize political candidates and justify political endorsements. The SMS and the WISPAC endorsement of Rep Scott Klug (R-Madison), as discussed in the February 1991 edition of the *Wisconsin Medical Journal*, is a recent example. If we keep these value laden phrases in our ideological lexicon, we will lose our ability to communicate with the public.

It is critical that organized medicine articulate a vision of health care reform built on consensus within our ranks that places the public first. The basic elements of a reform package should include:

- guaranteed access of all citizens to basic health care coverage including primary care, drug coverage and hospital care;
- financing spread evenly across all sectors of our economy;
- simplification of the paperwork mess that whets the appetite of the insurance industry while choking our economy so that this highly skilled segment of our work force can be redirected into productive jobs;
- physicians and provider organizations should remain private whenever possible; and
- cost-containment provisions that include reasonable co-payment mechanism to minimize frivolous use.

Support for a plan that meets these basic criteria should be part of our legislative agenda for 1992. If we fail to take an active role in health care reform our worst fears are more likely to be realized. Reform will bring cost-containment mechanisms on a global scale. Demand for hospital and nursing home care historically has been difficult to contain and will grow with the aging of our population.

The insurance industry, threatened with massive restricting, will redirect its enormous public relations engine and flex its political muscle to target physicians as the primary cause of medical inflation. The result will be further fee cuts and bureaucratic attempt to micromanage medical decision making.

We have an historic opportunity to take an active role in health care reform that enhances the quality of health care available to all of our patients and ultimately supports our interest as physicians. Let us be seen as the proponents of constructive change that identifies our patients' health as the most important interest of organized medicine.

–Duane M. Koons, MD
Viroqua

Editor's note: The SMS did not endorse Rep Scott Klug; the SMS does not endorse candidates of any kind. Although WISPAC recommeded that AMPAC endorse Rep Klug, the actual endorsement and contribution was made by the national organization; WISPAC does not endorse candidates for federal offices.[150th]

Taking a stand against smoking

To the editor: What a marvelous juxtaposition–at one end of the lobby of Seton Tower at St Mary's Hospital in Milwaukee appeared a sign proclaiming April as "National Cancer Month," while at the other end is the coffee shop, encouraging smoking with a brazen sign advertising "smoking allowed." The sign for "National Cancer Month" is gone, but the smoking sign remains.

The major health hazards of smoking are legendary. The risk to nonsmokers exposed to passive smoke are becoming increasingly prominent in both the scientific literature and in the news media. When are we, as physicians, healers and teachers, going to insist that hospital campuses become safe havens from smoke?

I encourage the SMS to take a stand on smoking, at least in our own institutions, and clear the air for our patients and ourselves.

–Paul D. Burstein, MD
Milwaukee

Editor's note: The SMS has taken such a stand many times, and will do so again in the future. For instance, in the most recent legislative session, the SMS joined with the Wisconsin Hospital Association in requesting, and winning, an amendment to the Wisconsin Clean Indoor Air Act. The 1991 Wisconsin Act 130, which becomes effective Oct 1, 1993, directs all hospitals and physicians offices to become smoke-free environments. An exception is made for inpatient facilities that care primarily for patients suffering mental illness or alcoholism and other drug abuse. Those facilities may designate a smoking area for those adult patients who have written permission of a physician. The bill responds to a resolution adopted by the SMS House of Delegates.[150th]

Soundings

A call for a national health care funding system

A GROWING CONSENSUS has emerged, diagnosing the American health care delivery system as being fundamentally sick. We spend 12% of our GNP on health care, considerably more than any other country, yet fail to provide insurance for 37 million Americans. Another 45-50 million Americans are considered underinsured. Japan, by comparison, spends only 6% of its GNP on health care–half of what we spend–yet Japan insures all of its citizens. The US infant mortality rate is worse than 20 other nations, and citizens of 15 countries live longer, on average, than Americans.

A recent Harvard University study showed that American's satisfaction with their health care was lowest of 10 industrialized countries surveyed. Only 10% of Americans were well satisfied with their health care. Canada's patient satisfaction was highest; 56% were well satisfied. How is it that Americans spend so much on health care, with less than exemplary results?

A major problem is that our current health care delivery system is heavily biased in favor of treating illnesses once they have become manifest, rather than preventing illness. Prevention is cost-effective and certainly desirable. Treating illness, especially with the use of today's increasingly expensive medical technologies, can be extraordinarily costly. As an example, many pregnant mothers don't have access to adequate prenatal care, without which babies are at increased risk for being born prematurely. Prematurity often leads to the need for long-term care in neonatal intensive care units, which can cost hundreds of thousands of dollars per infant.

As another example, insurance companies often do not pay for alcohol treatment programs, while at the same time they pay for liver transplants done because of advanced alcoholic cirrhosis. Liver transplants cost about $300,000, and the world's major liver transplant center, located in Pittsburgh, has no qualms about performing the procedure in 65-year-old chronic alcoholics.

In addition, insurance companies usually do not cover the cost of helping patients to quit smoking, even though cigarettes are linked with roughly 400,000

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premature deaths annually in America. Tens of thousands of these deaths are related to emphysema, and some smokers who develop emphysema have a relative deficiency in an enzyme, the replacement of which can slow the progression of the disease. Insurance companies may pay for this treatment, although the cost is exorbitant: approximately $25,000 per patient per year.

Preventing prematurity through access to adequate prenatal care and preventing the ravages of long-term alcohol and nicotine addiction are clearly desirable, but our current health care delivery system, with its perverse funding priorities, does not see things this way. Our current system was built on the premise of treating disease rather than preventing it, and it seems difficult to conceive that anything other than a nationally funded and managed health care system can reverse these priorities.

The United States leads the world in the development and application of high technology medicine, but increasing concern exists that dollars spent on high-tech medicine might be better spent elsewhere. The MRI scanner is the latest high-tech machine used in imaging the body. Ten years ago, nobody had MRI scanners. Now, in Eau Claire, both Luther and Sacred Heart hospitals have one.

In the United States last year 5 million MRI scans were performed, at a cost of about $1,000 each, for a total cost of about $5 billion. Few people would argue that society has actually received $5 billion of benefits from these scans.

Another cause for the high cost of American health care is the current private insurance system. More than 1,200 private insurers exist, all of which are trying to make a profit-which often means that those patients who are sickest and most in need of health insurance are least insurable. Patients know all too well how difficult it can be to get insurance if they have a so-called pre-existing condition. It has been estimated that shifting to a national funding mechanism for health insurance would save $33 billion annually in administrative costs by shifting from over 1,200 bureaucracies, all with

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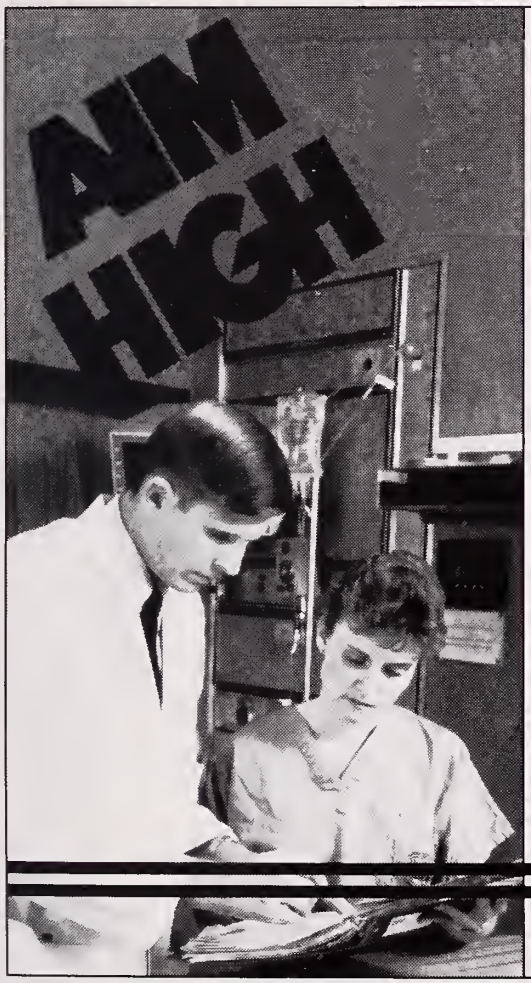
different forms and policies, to one. An additional $34 billion could be saved by eliminating insurance company profits and overhead. Currently in America, nearly 25 cents out of every health care dollar goes to administrative costs, a higher amount than any other country.

As an example of the difference in administrative costs between a US and a Canadian hospital, consider Minneapolis Hennepin County Medical Center, which employs 56 people in finance, nearly all in billing, and Ontario's Toronto Hospital which, though three times the size of Hennepin County, employs only 22 people in billing.

Many people believe that a Canadian-style health program is preferable to the current US system. All Canadians have the right to health coverage, they can choose their own doctors and clinics and, as mentioned, they are overall much more satisfied with their health care than are Americans. And, for those who might be concerned about the quality of care delivered by and efficiency of "government doctors," it's important to bear in mind that Canadian physicians are not civil servants. They are reimbursed for every patient they see, creating incentives for both industriousness and efficiency.

The concept of a national mechanism for funding health care is not a radical one; of developed countries, only the United States and South Africa do not guarantee their citizens the right to basic health care. The time for a national funding mechanism for health care in America is overdue.

–Steven Weiss, MD
Eau Claire[150th]



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The American Medical Association has formed a *National Coalition of Physicians Against Family Violence*. Through the *Coalition* the American Medical Association hopes to involve you in activities that address issues of child abuse, sexual assualt, domestic violence and elder abuse because you have the unique ability to identify the symptoms, first-hand. By joining the *National Coalition* you will be showing your concern about the effects of family violence and victimization, and will become a committed advocate within your community for the prevention of family violence.

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† If, after an adequate trial of ACCUPRIL alone, based on your medical judgment as the prescribing physician, you determine that your patient requires the addition of a diuretic, Parke-Davis will refund to the patient his/her cost for the diuretic prescription less any amount reimbursed or paid for by an HMO, insurance company, or any other plan or program.

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‡ In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

ACCUPRIL is available in 10, 20, and 40 mg tablets. Usual initial starting dosage is 10 mg once daily.

ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Please see brief summary of prescribing information on following page:

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PARKE-DAVIS

USE IN PREGNANCY
When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, ACCUPRIL should be discontinued as soon as possible. See WARNINGS, Fetal/Neonatal Morbidity and Mortality

Before prescribing, please see full prescribing information. A brief summary follows.

INDICATIONS AND USAGE
ACCUPRIL is indicated for the treatment of hypertension. It may be used alone or in combination with thiazide diuretics.

In using ACCUPRIL, consideration should be given to the fact that another angiotensin-converting enzyme (ACE) inhibitor, captopril, has caused agranulocytosis, particularly in patients with renal impairment or collagen vascular disease. Available data are insufficient to show that ACCUPRIL does not have a similar risk (see WARNINGS).

CONTRAINDICATIONS
ACCUPRIL is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

WARNINGS
Angioedema: Angioedema of the face, extremities, lips, tongue, glottis, and larynx has been reported in patients treated with ACE inhibitors and has been seen in 0.1% of patients receiving ACCUPRIL. Angioedema associated with laryngeal edema can be fatal. If laryngeal stridor or angioedema of the face, tongue, or glottis occurs, treatment with ACCUPRIL should be discontinued immediately, the patient treated in accordance with accepted medical care, and carefully observed until the swelling disappears. In instances where swelling is confined to the face and lips, the condition generally resolves without treatment, antihistamines may be useful in relieving symptoms. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, emergency therapy including, but not limited to, subcutaneous epinephrine solution 1:1000 (0.3 to 0.5 mL) should be promptly administered (see ADVERSE REACTIONS).**

Hypotension: Symptomatic hypotension was rarely seen in uncomplicated hypertensive patients treated with ACCUPRIL but, as with other ACE inhibitors, it is a possible consequence of therapy in salt/volume depleted patients, such as those previously treated with diuretics or dietary salt restriction or who are on dialysis (see PRECAUTIONS, DRUG INTERACTIONS, and ADVERSE REACTIONS). In controlled studies, syncope was observed in 0.4% of patients (N = 3203), this incidence was similar to that observed for captopril (1%) and enalapril (0.8%).

In patients with concomitant congestive heart failure, with or without associated renal insufficiency, ACE inhibitor therapy may cause excessive hypotension, which may be associated with oliguria or azotemia and, rarely, with acute renal failure and death. In such patients, ACCUPRIL therapy should be started at the recommended dose under close medical supervision. These patients should be followed closely for the first 2 weeks of treatment and whenever the dosage of antihypertensive medication is increased (see DOSAGE AND ADMINISTRATION).

If symptomatic hypotension occurs, the patient should be placed in the supine position and, if necessary, normal saline may be administered intravenously. A transient hypotensive response is not a contraindication to further doses; however, lower doses of ACCUPRIL or reduced concomitant diuretic therapy should be considered.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression rarely in patients with uncomplicated hypertension, but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease such as systemic lupus erythematosus or scleroderma. Agranulocytosis did occur during ACCUPRIL treatment in one patient with a history of neutropenia during previous captopril therapy. Available data from clinical trials of ACCUPRIL are insufficient to show that, in patients without prior reactions to other ACE inhibitors, ACCUPRIL does not cause agranulocytosis at similar rates. As with other ACE inhibitors, periodic monitoring of white blood cell counts in patients with collagen vascular disease and/or renal disease should be considered.

Fetal/Neonatal Morbidity and Mortality: ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of ACCUPRIL as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, ACCUPRIL should be discontinued unless it is considered life-saving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as a means of reversing hypotension and/or substituting for disordered renal function. Removal of ACCUPRIL, which crosses the placenta, from the neonatal circulation is not significantly accelerated by these means.

No teratogenic effects of ACCUPRIL were seen in studies of pregnant rats and rabbits. On a mg/kg basis, the doses used were up to 180 times (in rats) and one time (in rabbits) the maximum recommended human dose.

PRECAUTIONS
General
Impaired renal function: As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including ACCUPRIL, may be associated with oliguria and/or progressive azotemia and rarely acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine have been observed in some patients following ACE inhibitor therapy. These increases were almost always reversible upon discontinuation of the ACE inhibitor and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some hypertensive patients with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when ACCUPRIL has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of any diuretic and/or ACCUPRIL may be required.

Evaluation of hypertensive patients should always include assessment of renal function (see DOSAGE AND ADMINISTRATION).

Hyperkalemia and potassium-sparing diuretics: In clinical trials, hyperkalemia (serum potassium ≥5.8 mmol/L) occurred in approximately 2% of patients receiving ACCUPRIL. In most cases, elevated serum potassium levels were isolated values which resolved despite continued therapy. Less than 0.1% of patients discontinued therapy due to hyperkalemia. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with ACCUPRIL (see PRECAUTIONS, Drug Interactions).

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent, and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, ACCUPRIL will block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients
Pregnancy: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

Angioedema: Angioedema, including laryngeal edema, can occur with treatment with ACE inhibitors, especially following the first dose. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to stop taking the drug until they have consulted with their physician (see WARNINGS).

Symptomatic hypotension: Patients should be cautioned that lightheadedness can occur, especially during the first few days of ACCUPRIL therapy, and that it should be reported to a physician. If actual syncope occurs, patients should be told to not take the drug until they have consulted with their physician (see WARNINGS).

All patients should be cautioned that inadequate fluid intake or excessive perspiration, diarrhea, or vomiting can lead to an excessive fall in blood pressure because of reduction in fluid volume, with the same consequences of lightheadedness and possible syncope.

Patients planning to undergo any surgery and/or anesthesia should be told to inform their physician that they are taking an ACE inhibitor.

Hyperkalemia: Patients should be told not to use potassium supplements or salt substitutes containing potassium without consulting their physician (see PRECAUTIONS).

Neutropenia: Patients should be told to report promptly any indication of infection (eg, sore throat, fever) which could be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with ACCUPRIL is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions
Concomitant diuretic therapy: As with other ACE inhibitors, patients on diuretics, especially those on recently instituted diuretic therapy, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with ACCUPRIL. The possibility of hypotensive effects with ACCUPRIL may be minimized by either discontinuing the diuretic or cautiously increasing salt intake prior to initiation of treatment with ACCUPRIL. If it is not possible to discontinue the diuretic, the starting dose of quinapril should be reduced (see DOSAGE AND ADMINISTRATION).

Agents increasing serum potassium: Quinapril can attenuate potassium loss caused by thiazide diuretics and increase serum potassium when used alone. If concomitant therapy of ACCUPRIL with potassium-sparing diuretics (eg, spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes is indicated, they should be used with caution along with appropriate monitoring of serum potassium (see PRECAUTIONS).

Tetracycline and other drugs that interact with magnesium: Simultaneous administration of tetracycline with ACCUPRIL reduced the absorption of tetracycline by approximately 28% to 37%, possibly due to the high magnesium content in ACCUPRIL tablets. This interaction should be considered if coprescribing ACCUPRIL and tetracycline or other drugs that interact with magnesium.

Lithium: Increased serum lithium levels and symptoms of lithium toxicity have been reported in patients receiving concomitant lithium and ACE inhibitor therapy. These drugs should be co-administered with caution, and frequent monitoring of serum lithium levels is recommended. If a diuretic is also used, it may increase the risk of lithium toxicity.

Other agents: Drug interaction studies of ACCUPRIL with other agents showed:
- Multiple dose therapy with propranolol or cimetidine has no effect on the pharmacokinetics of single doses of ACCUPRIL.
- The anticoagulant effect of a single dose of warfarin (measured by prothrombin time) was not significantly changed by quinapril coadministration twice-daily.
- ACCUPRIL treatment did not affect the pharmacokinetics of digoxin.
- No pharmacokinetic interaction was observed when single doses of ACCUPRIL and hydrochlorothiazide were administered concomitantly.

Carcinogenesis, Mutagenesis, Impairment of Fertility
Quinapril hydrochloride was not carcinogenic in mice or rats when given in doses up to 75 or 100 mg/kg/day (50 to 60 times the maximum human daily dose, respectively, on a mg/kg basis and 3-8 to 10 times the maximum human daily dose when based on a mg/m² basis) for 104 weeks. Female rats given the highest dose level had an increased incidence of mesenteric lymph node hemangiomas and skin/subcutaneous lipomas. Neither quinapril nor quinaprilat were mutagenic in the Ames bacterial assay with or without metabolic activation. Quinapril was also negative in the following genetic toxicology studies: *in vitro* mammalian cell point mutation, sister chromatid exchange in cultured mammalian cells, micronucleus test with mice, *in vitro chromosome* aberration with V79 cultured lung cells, and in an *in vivo* cytogenetic study with rat bone marrow. There were no adverse effects on fertility or reproduction in rats at doses up to 100 mg/kg/day (60 and 10 times the maximum daily human dose when based on mg/kg and mg/m², respectively).

Pregnancy
Pregnancy Categories C (first trimester) and D (second and third trimesters): See WARNINGS, Fetal/Neonatal Morbidity and Mortality

Nursing Mothers
It is not known if quinapril or its metabolites are secreted in human milk. Quinapril is secreted to a limited extent, however, in milk of lactating rats (5% or less of the plasma drug concentration was found in rat milk). Because many drugs are secreted in human milk, caution should be exercised when ACCUPRIL is given to a nursing mother.

Geriatric Use
Elderly patients exhibited increased area under the plasma concentration-time curve (AUC) and peak levels for quinaprilat compared to values observed in younger patients; this appeared to relate to decreased renal function rather than to age itself. In controlled and uncontrolled studies of ACCUPRIL where 918 (21%) patients were 65 years and older, no overall differences in effectiveness or safety were observed between older and younger patients. However, greater sensitivity of some older individual patients cannot be ruled out.

Pediatric Use
The safety and effectiveness of ACCUPRIL in children have not been established.

ADVERSE REACTIONS
ACCUPRIL has been evaluated for safety in 4960 subjects and patients. Of these, 3203 patients, including 655 elderly patients, participated in controlled clinical trials. ACCUPRIL has been evaluated for long-term safety in over 1400 patients treated for 1 year or more.

Adverse experiences were usually mild and transient.

Discontinuation of therapy because of adverse events was required in 4.7% of patients treated with ACCUPRIL in placebo-controlled hypertension trials.

Adverse experiences probably or possibly related to therapy or of unknown relationship to therapy occurring in 1% or more of the 1563 patients in placebo-controlled hypertension trials who were treated with ACCUPRIL are shown below:

Adverse Events in Placebo-Controlled Trials

	ACCUPRIL (N = 1563) Incidence (Discontinuance)	Placebo (N = 579) Incidence (Discontinuance)
Headache	5.6 (0.7)	10.9 (0.7)
Dizziness	3.9 (0.8)	2.6 (0.2)
Fatigue	2.6 (0.3)	1.0
Coughing	2.0 (0.5)	0.0
Nausea/Vomiting	1.4 (0.3)	1.9 (0.2)
Abdominal Pain	1.0 (0.2)	0.7

See PRECAUTIONS, Cough.

Clinical adverse experiences probably or possibly related, or of uncertain relationship to therapy, occurring in 0.5% to 1.0% (except as noted) of the patients treated with ACCUPRIL (with or without concomitant diuretic) in controlled or uncontrolled trials (N = 4397) and less frequent, clinically significant events seen in clinical trials or post-marketing experience (the rarer events are in italics) include (listed by body system):

General: back pain, malaise

Cardiovascular: palpitation, vasodilation, tachycardia, *heart failure, hyperkalemia, myocardial infarction, cerebrovascular accident, hypertensive crisis, angina pectoris, orthostatic hypotension, cardiac rhythm disturbances*

Gastrointestinal: dry mouth or throat, constipation, *gastrointestinal hemorrhage, pancreatitis, abnormal liver function tests*

Nervous/Psychiatric: somnolence, vertigo, syncope, *nervousness, depression*

Integumentary: increased sweating, pruritus, *exfoliative dermatitis, photosensitivity reaction*

Urogenital: *acute renal failure*

Other: amblyopia, pharyngitis, sinusitis, bronchitis, *agranulocytosis, thrombocytopenia*

Fetal/Neonatal Morbidity and Mortality
See WARNINGS, Fetal/Neonatal Morbidity and Mortality.

Angioedema: angioedema has been reported in patients receiving ACCUPRIL (0.1%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with ACCUPRIL should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Clinical Laboratory Test Findings
Hematology: (See WARNINGS)
Hyperkalemia: (See PRECAUTIONS)
Creatinine and blood urea nitrogen: Increases (↑1.25 times the upper limit of normal) in serum creatinine and blood urea nitrogen were observed in 2% and 2%, respectively, of patients treated with ACCUPRIL alone. Increases are more likely to occur in patients receiving concomitant diuretic therapy than in those on ACCUPRIL alone. These increases often remit on continued therapy.

*In some patients, the antihypertensive effect may diminish toward the end of the once-daily dosing interval. In such patients, an increase in dosage or twice-daily administration may be warranted.

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Domestic violence: an overview

"Domestic violence is a cancer that gnaws at the body and soul of the American family."
–US Surgeon General Antonio Novello, MD

Shari Hamilton, assistant editor

THE NATIONAL STATISTICS are formidable: family violence affects one fourth of all American families; domestic violence is responsible for one third of female murders; and half of all adult women will be victims of family violence--more than once. Every year, more than a million children in the United States are seriously abused by their parents, guardians or others, and between 2,000 and 5,000 children die as the result of their injuries. Elder abuse is another area of growing concern.

Closer to home, the Wisconsin news isn't any better. As many as 10,000 women are battered each year in Dane County alone, estimates the Dane County Advocates for Battered Women. In 1991, there were 1,866 child abuse and neglect cases reported in Dane County–an increase of 7.5 percent from 1990.

The Wisconsin Department of Health and Social Services reports that more than 7,000 battered women and children spent more than 85,000 nights in shelters and safe houses in 1990. Twelve percent of those seeking refuge were turned away because the shelters were full, said Mary Lauby, state domestic abuse program coordinator.

An average of 140 crisis calls are made each day. Outside of Milwaukee, 70% of all murders were of a family member or intimate partner. Sixty-three percent of youthful offenders who commit murder do so to kill abusers of their mothers, Lauby reported.

Violence, according to Surgeon General Novello, is the second most common cause of injury overall in the United States, and the leading cause of injuries to women aged 15 to 44. "Our society is too violence tolerant. Violence has become

Continued on next page

SMS poster campaign aimed at opening lines of communication

HAVE YOU EVER SUSPECTED someone might have been the victim of domestic violence, but turned away, thinking, "It's really none of my business"? Annual estimates have reported domestic violence injuries to include:

- 21,000 hospitalizations;
- 9,800 days of hospitalizations;
- 28,700 emergency room visits;
- 39,000 physician visits;
- 175,000 days lost from work; and
- $44 million in total annual medical costs.

These are just the economic costs; it's impossible to tally the overall cost of domestic violence to our society. It has become glaringly apparent–sooner or later, domestic violence is everyone's business. Too many people have been injured while we all minded our own concerns. Some, as the headlines reveal, have even died.

The SMS will soon embark on a poster campaign to increase awareness and stop domestic violence in Wisconsin. The posters will feature a background of news clippings, depicting some of the many cases of domestic violence in our state. The poster's text will encourage patients to talk to their doctors about violence in their homes. By displaying these posters in your waiting room, examining room or office, you will indicate to your patients that you are available to talk with them and will help them access important resources.

Watch *Medigram* for more details on poster distribution.[150th]

Continued from preceding page
mainstream. We must address the complex problem of a violence-saturated society as a public health issue and combat it in our mass media, in our classrooms and at home," the surgeon general said, in a recently released statement.

The problem of family violence is "beyond the reach of the criminal justice system alone" and public health must play a greater role in prevention, observed Mark Rosenberg, MD, director of the division of injury control for the Centers for Disease Control in Atlanta, during a recent AMA briefing on family violence.

To decrease violence in our society, Rosenberg said Americans must focus on changing attitudes that legitimize violence in society, and strive to change behaviors by teaching children and adolescents alternate responses to stress and conflict.

In Wisconsin, Lauby said, there has been increased awareness of family violence since the implementation of the Domestic Abuse Manditory Arrest Law in 1989. There are no state mandates to provide services to battered women, however, so the only support comes from private, non-profit organizations. State dollars do provide support, accounting for about one third of all funding for domestic violence programs. Programs for abusers, especially in rural areas, are often left to local mental health programs because other outlets are not available.

Rather than develop new programs to help battered women in the state, Lauby recommends support for existing programs with increased emphasis on treatment for children who have witnessed family violence.

Lauby also sees a need for physicians to expand their role in the fight against domestic abuse. "Physicians have more contact with battered women and children than clergy, educators, social workers and the criminal and civil systems. Given their (physicians) status in the eyes of the community at large, their ability to engender trust on behalf of patients, they are more likely to identify larger numbers of battered women and kids and have a much more significant role in terms of imparting information that can help women be safe," Lauby said.

Increased education of physicians, the state official said, will help doctors identify victims, and gain a better understanding of who battered women are and why they do what they do.

"Medicating a battered woman who is chronically depressed isn't going to do anything about the reason she's depressed," the program coordinator stated. "And just telling a woman to get out (of the home), isn't a good response. Often, that isn't possible; if she could get out, she would."

The AMA is now working to develop guidelines to help physicians identify and treat patients who are victims of abuse in the home. The AMA Diagnostic and Treatment Guidelines will cover child sexual abuse, domestic violence (violence between intimate partners) and elder abuse.

"The guidelines are designed expressly for front-line, primary-care physicians–the doctors who see the bruises, stitch up the cuts and set the broken bones that are the results of family violence and abuse," explained Robert E. McAfee, MD, vice chair of the AMA Board of Trustees, in a news release. "These protocols can help in preventing family violence or stopping it before it destroys lives, families and communities."[15,16]

Empowering physicians to respond to domestic violence

Kevin J. Fullin, MD, and Amanda Cosgrove, BA, Kenosha

Despite the progress of the last 15 years in combating family violence, some individuals, community agencies and institutions still support a man's "right" to control, and they often disregard the physical violence he uses. Because threats and assault are in fact against the law, a man who physically or sexually assaults his wife or girlfriend couldn't keep doing it without this support from the very people who are supposed to enforce the law and help the victims of crime–namely, police, prosecutors, judges, clergy, psychologists, social workers and doctors. Some let him get away with it, look the other way, or–unsure of what to do to stop it–do nothing at all. Thus, they reinforce his "right" to use force, even if they never say, "Go ahead, hit her." The police officer who walks a man around the block or fails to show up when called, the clergyman who advises a woman to go home and pray, the doctor who gently patches her injuries but avoids asking who inflicted them, all cooperate with the abusive man in several ways. He comes to understand that no one will stop him from doing what he does. He learns that there are no consequences to his actions–even his violent actions. He can beat up "his woman" if he wants to and get away with it.[1]

Dr Fullin is the medical director of the Domestic Violence Project in Kenosha. Cosgrove is the coordinator of the Domestic Violence Project. Reprint requests to: Kevin J. Fullin, MD, Kenosha Cardiology Associates, 6308 8th Ave, Suite 402, Kenosha, WI 53143. Copyright 1992 by the State Medical Society of Wisconsin.

PHYSICIANS THROUGHOUT Wisconsin and across the country, in hospital emergency departments and private practice, are beginning to acknowledge and recognize a large deficit in their knowledge of clinical assessment and treatment of victims of domestic abuse. Whether practicing primary care medicine, internal medicine, or specialized medicine such as emergency medicine, psychiatry, obstetrics or surgery, physicians have daily encounters with patients who are experiencing symptoms and injuries secondary to violence in their intimate relationships. Yet a lack of physician acknowledgement of the violence in patients' lives is predominant and has severe morbidity and mortality consequences for victims seeking health care. Physicians must take a new and active role in the process of identifying and treating victims of domestic abuse; to ignore this issue is simply poor medical practice.

Battering is the single most common cause of injury to women–more frequent than automobile accidents, muggings and rapes combined.[3] More than 1 million women seek medical care for symptoms related to ongoing abuse.[4] Numerous studies document that between 22% and 35% of all visits to the emergency room by women are directly related to abuse or the stress related to ongoing abuse.[2,3,5,6] Traditionally, health care professionals and physicians have had little training regarding domestic abuse; a shocking reality given the number of victims treated everyday in their practice.

Domestic violence has not traditionally fallen into the realm of physicians medical practice. This is reflected by the dearth of formal education in medical school and post-graduate training regarding domestic violence. Domestic abuse is not a disease; one cannot order a laboratory test to confirm its existence. Rather, domestic abuse is a societal problem that has extreme medical consequences. These medical consequences lead many victims into the health care system for assistance. Most abused women are in fact reaching for help when seeking medical care, and are actually relieved to be asked about their situation.

A battered woman's testimony reflect this, "I was terrified that someone would ask me how I got my injuries. I was just as terrified that no one would ask and I would have to return home without talking to anyone about what was happening to me."[7]

How do physicians know who to ask about abuse in a relationship? Who is at risk and how do victims of abuse present in the health care setting? The most evident sign of abuse is physical injury. Common injuries include lacerations, hematoma, fractures, abrasions, and burns. These injuries, both major and minor, are usually located on the trunk of the body, and often are in various stages of healing at the time of presentation to a physician. While these are obvious clues in a patient's examination, if one only looks for severe physical trauma the majority of victims will be missed by the screening.

Patients who have a multiplicity of symptoms or symptom complex which may be related to stress should always be screened for the possibility of domestic abuse. Complaints such as shortness of breath, palpitations, atypical chest pain, abdominal pain, pelvic pain, migraines, insomnia, alcohol and drug abuse, depression, and suicide attempts are examples of common manifestations of abuse. Patients with ongoing symptoms of abuse have frequent and recurrent health care interactions that often leave them with labels such as crock, hypochondriac, or problem patient. Physicians, ill trained to identify these victims, may fail to discover the underlaying cause of these patients' symptoms and, out of frustration, may label them. These labels do not lead to useful diagnosis or therapeutic treatment, but rather give the message to the patient and other providers that spending time with her is not worthwhile.[8]

Fig 1.–Understanding the concepts of power and control.

It is clear, from the variety and multiplicity of clues suggestive of abuse in patients lives, that physicians need to assess all female patients for domestic abuse. Rather than asking solely about injury, we must ask patients about the dynamics of their significant relationships. *Do you feel inequality in the relationship? Do you ever feel controlled or afraid? What happens when you disagree?*

Screening questions like the samples here enable physicians and patients to recognize abusive relationships, perhaps before physical injuries manifest. In addition, the identification of abuse in the patient's life allows physicians to have a better understanding of their patients' lives as it affects their medical symptoms. By asking about the possibility of violence, listening, and believing what she tells you, you are assisting her in identifying the abuse and breaking the isolation she lives under. Few people in her life are likely to understand the dynamics of the abuse and, as a result, most will react inappropriately by blaming her and minimizing the violence against her. Simply put, assessing all female patients for dynamics of power and control in their relationships, with consideration of their symptoms, and an understanding of the significant clues in the

Continued on next page

physical examination is a standard of good medical care.

Yet, even with the wealth of information available to assist physicians in identifying patients trapped in abusive relationship, most physicians do not fulfill this responsibility. Physicians' attitudes regarding domestic abuse reflect our societies denial of the prevalence and severity of abuse perpetrated against women and children.

For a physician, learning how to address these issues goes beyond asking a few simple questions, requiring the physician to address the power and control imbalances within his or her relationships with family, colleagues, and patients. If a physician has a patriarchal relationship at home, it is difficult to imagine how he could be empowering to a patient struggling in a controlling relationship. For other physicians, asking about abuse can elicit uncomfortable feelings related to previous personal experiences of abuse. Physicians examining abuse issues within their own lives may have to address the normalization of abusive behavior and blaming issues, and this can also be emotionally painful.

For assessment and intervention strategies to be helpful, physicians must be guided by a conceptual framework that views power and control as the root of the violence perpetuated against women and children in this country. Without a clear understanding of the dynamics of power and control in intimate relationships, and society at large, physician intervention is likely to contribute to the ongoing victimization of women and children.[8]

Domestic abuse is perpetrated within our society, reflecting and reinforcing the established historical hierarchies of inequality. Perpetrators of domestic abuse use their power (physical, social, political, and economic) to gain and maintain control and inequality over their victims. As a first step toward appropriate care, it is critical to understand the concept of power and control (Figure 1). Without this understanding as a framework for addressing the problem of abuse, intervention with victims is likely to be judgmental, ineffective, and dangerous. Understanding the concept of power and control is the foundation for intervention (Figure 2).

With an understanding of power and control dynamics in abusive relationships, the most effective role for physicians to take is that of a patient advocate (Figure 3). Being a patient advocate is what being a physician is all about. In treating victims of domestic abuse, the physician's role as an advocate is no different. Crucial to the effective intervention are six spokes to advocacy: confidentiality, believing and validating her reported experiences, acknowledging the injustice, respecting her autonomy, safety planning, and promoting access to community services.

Confidentiality

As a first step, confidentiality must be established. Discussing the possibility of victimization must occur in private. A victim of domestic abuse will not typically disclose a history of violence in the presence of her perpetrator or other family member. If she discloses the violence in this presence, it is likely she will suffer retaliation.

Acknowledge injustice

Let her know that the violence perpetrated against her is not her fault. No one deserves to be abused. No one has the right to use violence and intimidation to control another person in an effort

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Fig 2.–Understanding the foundation for physician intervention.

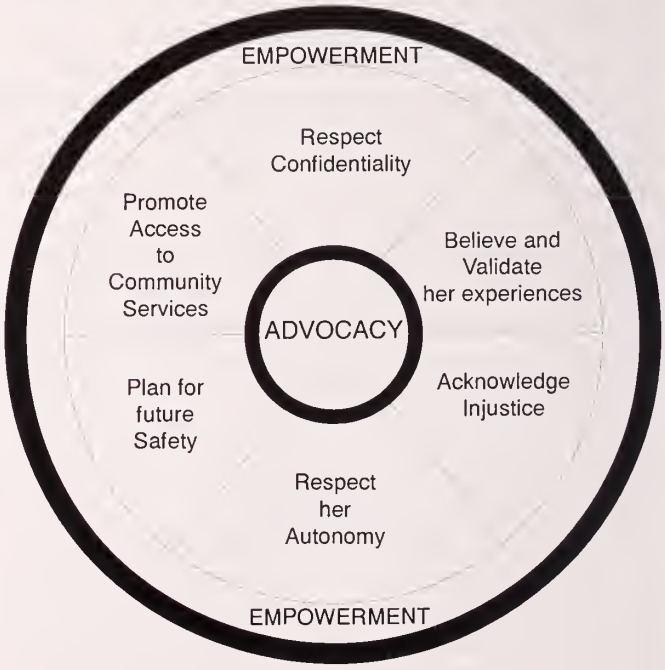

Fig. 3–The role of physicians as patient advocates.

to keep them in a relationship. What has happened is not her fault.

Autonomy
Empowering advocacy is based on the fundamental belief that victims of domestic violence have the right to control their own lives. In their process of victimization, control has been taken away from them. In your interaction with a victim, you can give her that control back, by respecting decisions and reaffirming that she has the right to live a life free of violence and coercion.

Safety planning
What are a victim's options? Does she want to go home, to the home of a friend or family members, or to a local safe house or shelter? What has she done to protect herself in the past? If she's returning home to her partner, can she plan for a quick escape should the violence begin again? Can she call law enforcement officials for protection?

Promote access to community services
Know the resources in your community. Inform her of services available that may be able to provide additional assistance. Is there a program for battered women in your community?

Effective and appropriate intervention based on the patient advocacy model described above respects a woman's ability to make decisions regarding her own life and empowers her in the process. Fundamental to advocacy is not to tell a woman what to do, second guess her decisions, or perceive her at fault for the consequences of the violence perpetrated against her. Instead, working together, to assist her in building on her strengths, defending her rights, and ultimately respecting her decisions regarding when and how to take the next step is an empowering intervention approach. She is the expert in her own life, and will make her decisions based on the circumstances of her life and in the best interests of herself and her children. Support her as she sorts through her many considerations; her mixed feelings toward her partner, financial options, danger of intensified violence if she attempts to leave, and effects on the children of staying in or leaving the relationship.

As physicians assume the role of a patient advocate with victims of domestic abuse, steps are made toward empowering patients. These steps are of extreme importance in the process of empowering victims. Imagine a ladder, with the rungs representing steps toward empowerment (Figure 4). Taking this mnemonic of "LADDERS TO EMPOWERMENT," your ability to reach each rung on the ladder is a step toward becoming an advocate for the victim. Using every rung on the ladder facilitates a higher level of empowerment. By following this model of advocacy and empowerment, a physician's treatment of victims reaches an appropriate standard of care. To fall short of these standards is poor medical practice, weakens victims, and contributes to the consequences of victimization.

L isten and believe her experiences of abuse
A ssure her that she is not alone and she is not to blame
D efend her right to live without the fear of violence
D efer from overly prescribing sedative medicines
E ncourage her to seek supportive services in the community
R espond to her need for safety planning
S upport her decisions
. . . to empowerment!

Fig 4.–The steps to empowerment.

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The role of health care workers in responding to battered women

Nancy Worcester, PhD, Madison

Battering appears to be the single most common cause of injury to women–more common than automobile accidents, muggings and rapes combined.[1]

Effective Jan 1, 1992, all accredited hospitals are required to have protocols in place describing how they respond to battered women and how health professionals are trained on this issue. This is the ideal time for health care workers and battered women's advocates to work together to make sure that protocols serve to empower battered women. There are more than 1,000 programs in the United States specifically serving battered women. These experts can help a woman with the legal, safety, housing and support services she needs. The national domestic violence hotline, 800-333-SAFE, can give you the names and address of resources in your community.

Many women identify violence in their lives, and their fear of violence, as the number one health issue they face. For health care workers responding to battering, it is important to remember that battering is much more than the physical injuries. Violence serves as an excellent reminder that mental and physical health issues cannot be separated. For a woman being abused, physical violence is but one of the tools that her abuser uses to have power and control over many, or all, aspects of her life. Many formerly battered women who have even suffered life threatening injuries say that the physical violence was nothing compared to the psychological and emotional abuse they endured.

Now that many states have mandatory arrest laws, battered women have been quick to remind us that stopping the abuse in a home is much more complex than simply stopping the hitting. Women have noted that a result of abuser counselling can be that abusers learn they can no longer get away with hitting their partners. Unless larger issues of power and control are also addressed, however, the abuser may learn to shift to psychological and emotional forms of abuse and the woman continues to be battered even if she is no longer physically injured.

A wide range of chronic health issues including headaches, backaches, sleep disorders, anxiety, abdominal complaints, eating disorders, depression and chronic pain are particularly common in battered women and are clearly related to the stress of living in a violent relationship.

Dr Worcester is on the board of the National Women's Health Network. She teaches women's health at the University of Wisconsin and coordinates the Wisconsin Domestic Violence Health Training Project. For 4 years, she has worked as the state education coordinator for the Wisconsin Coalition Against Domestic Violence.
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The depth of the problem

The FBI estimates that a woman is beaten every 15 to 18 seconds in this country. Violence affects women of all social groups, ages, races, rural and urban environments, and affects both rich and poor and both heterosexual and lesbian women. Many health care workers and health care workers' partners live with violence as a part of their lives.

Battered women regularly call on the health system even though health care workers have a poor record of identifying them. Studies have shown that abused women have more health problems than non-abused women,[2] so those who trust the health system and have insurance probably seek health care at disproportionately high rates. Studies have shown that 22% to 35% of all women who use emergency room services are battered women and, because the same women may need to return time and time again, almost half of the injuries women have when they arrive in emergency rooms may be due to abuse.

Although health care workers do not regularly ask about battering during pregnancy, it is more common then and has as serious consequences (increased rates of miscarriage, stillbirth, low birth weight babies, and risk of homicide) as the conditions routinely tested for in prenatal care. Retrospective studies of battered women have found that 40% to 60% were abused during pregnancy; 25% of battered women say they were beaten for the first time during a pregnancy. The problems may be even more exaggerated in pregnant teenagers. One study[3] found that 26% of pregnant teens were currently in a relationship with a man who was abusive; many stated that the abuse had started when they discovered they were pregnant. Most alarming, 65% of the battered teens had not talked to anyone about the violence in their lives.

Health care workers' role

Many battered women would like to tell someone about the violence in their lives and would greatly benefit from knowing that their situation is not unusual and that there are a range of excellent resources available to them. Understanding common patterns of domestic violence make it obvious that health care workers who do recognize battered women and empower them to explore their options can play a key role in helping women end the violence in their lives.

Isolation

Isolation is a primary weapon that one person can use to gain control over another person's life. Battered women describe how abusers gradually isolate them from their other social and emotional support networks, so that eventually the abuser is the main person in her life giving her information

about her own value. Messages such as "No one else will ever love you" and "You deserve to be beaten" become powerful when a woman is not hearing any other messages.

Understanding that isolation is a consequence, not a cause, of battering can help health care workers recognize that what they say to battered women can be extremely important. Health care workers aware of power imbalances in health care worker-patient relationships can see how this can be exaggerated when the patient is an abused woman. A health care worker who implies that the woman is "the problem" will reinforce the messages she gets at home; the health care worker who says "You don't deserve to be hit" will be giving a crucial, different message.

Cycle of violence

The cycle of violence is a pattern that most battered women start to recognize in their lives. The battering incident seldom comes from "nowhere," but is the expected "explosion" from a period of increasing tension. Women describe the stress of living in the tension building stage, waiting for the straw which will provoke the battering, as so awful that some women remember when even a severe battering was almost a welcome "release" from the unbearable tension.

Particularly in the early years of abusive relationships, the battering incident is almost always immediately followed by a good stage, which some women call the "honeymoon" stage. The honeymoon stage is the wonderful stage we all want in relationships.

Understanding the importance of the honeymoon stage in battering relationships can help us understand the complexities of these, and all, relationships. This is the stage at which abusers say, and think they mean, that they are very sorry and that the abuse will never happen again. This is the stage when loving sexual intercourse and extravagant presents, mingled with a renewing of dreams and lifelong plans and goals, can be enticing.

If the battering is severe enough to cause injuries, the health care worker, particularly emergency service providers, may see the woman immediately after the battering and before the honeymoon stage. This is a key time to make sure the woman knows her options and resources, because she may be the most open to exploring alternatives to staying in a violent relationship. Once the honeymoon stage begins, the woman may be locked into another cycle, convinced that if only she tries harder the violence will end.

Escalation

Unless there is intervention and a sincere commitment from the abuser to learn entirely new ways of communicating in the relationship, battering relationships tend to escalate over time. The battering incidents become more frequent and often increase in severity. Battered women describe the honeymoon stage as being less of a "hook" in long-term battering relationships than the enormous social and eco-

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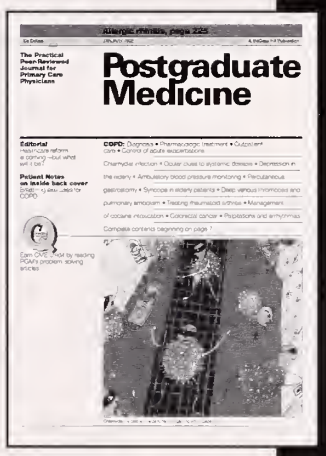
US THEM



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Postgraduate Medicine

Continued from preceding page
nomic pressures that keep them in relationships they know are unhealthy.

Because battered women may be seeing health care workers long before they turn to other services, good medical records with clear notes, and even photographs, of injuries and chronic health problems that may be related to domestic violence are essential. These can help health care workers who will see the records in the future, and the battered woman herself, to see the emerging pattern.

Blaming the victims

Even though health care workers are not good at identifying battered women, studies have found that they do treat battered women differently than non-battered women and that the treatment actually contributes to the consequences of battering. Unless there is an understanding of battering, a woman who calls on the health care system regularly, with a range of symptoms and injuries, may be seen as a frustrating patient by health care workers who pride themselves in being able to diagnose and treat specific conditions.

Only 5% to 10% of battered women in emergency services are identified as such by physicians on their records. Instead, the ground-breaking work on this[4] found that medical records included the labels "neurotic," "hysteric," "hypochondriac" or "a well-known patient with multiple vague complaints" for one in four battered women compared to one in 50 non-battered women. One in four battered women were given pain medications or minor tranquilizers compared to one in 10 non-battered women. Unfortunately, medication and victim labels reinforce the woman's feeling that she is the problem and may contribute to depression, drug and alcohol abuse, and high rate of suicide attempts that are seen as consequences of battering.

Empowering battered women

Excellent resources are now available for health care workers spelling out specific ways to identify and respond to battered women and to help them end the violence in their lives. Responding more appropriately to battered women does not necessarily mean more work for the health care worker. It means starting to ask about violence–"Since so many women are hurt by their partners, we ask every patient with injuries like yours whether they've ever been hit, kicked, or hurt by their partners."–and documenting it, making sure safety issues are addressed for a woman before she returns to the situation which caused the mental or physical injuries, giving women information about community resources, and stop giving abused women only labels and tranquilizers.

Battered women must be empowered to make their own decisions at their own pace. Outside intervention, certain behaviors, or attempts to leave at the wrong time can escalate the violence. Thirty percent of women murdered in this country are killed by the men they had loved. Most of these murders occur when women are trying to get out of a relationship. Understanding the complexities of leaving battering relationships is central to serving battered women's needs.

Health care workers will seldom know the effects of their responses to battered women. Saying "You don't deserve to be treated like this" or "Here is a list of community resources" may be the medical advice that saves more lives and does more for the mental health of patients than many more medical skills.

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Wisconsin domestic abuse programs, by county

Ashland
New Day Shelter-Northwoods Women
PO Box 88
Ashland, WI 54806
715-682-9566

Brown
Family Violence Center, Inc
PO Box 13536
Green Bay, WI 54307
414-498-8282

Chippewa
Family Support Center
28 E Columbia St
Chippewa Falls, WI 54729
715-723-1138

Columbia
STRIVE
PO Box 758
Portage, WI 53901
608-742-7677

Dane
Dane County Advocates
for Battered Women
PO Box 1145
Madison, WI 53701
608-251-1237

Wisconsin Coalition
Against Domestic Violence
1051 Williamson St
Madison, WI 53703
608-255-0539

Lavendar (for Lesbians)
c/o The United, Inc
310 E Wilson
Madison, WI 53703
608-241-5654

Dodge
P.A.V.E.
PO Box 561
Beaver Dam, WI 53916
414-887-3785

Door
HELP of Door County, Inc
PO Box 319
Sturgeon Bay, WI 54235
414-743-8818

Douglas
Center Against Sexual
and Domestic Abuse
2231 Catlin Ave
Superior, WI 54880

Human Resource Center
39 N 25th St
Superior, WI 54880
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Dunn
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Eau Claire, WI 54702-0482

Fond du Lac
Friends Aware of
Violent Relationships (FAVR)
PO Box 1752
Fond du Lac, WI 54935
414-922-7760

Grant
Family Advocates, Inc
PO Box 705
Platteville, WI 53818
608-348-5995

Green
Green Haven
PO Box 181
Monroe, WI 53566
608-325-7711

Jefferson
People Against Domestic Abuse
414-563-7040

Jefferson County HSD
N 3995 Annex Rd
Jefferson, WI 53549
414-674-3105

Kenosha
Women's Horizons, Inc
PO Box 792
Kenosha, WI 53141
414-652-1846

Kewaunee
Kewaunee County
Domestic Abuse Services
PO Box 52
Kewaunee, WI 54216
414-388-0811

La Crosse
YMCA New Horizons
PO Box 2031
La Crosse, WI 54602-2031
608-791-2600

Lac du Flambeau Reservation
Lac du Flambeau
Domestic Abuse Program
PO Box 67
Lac du Flambeau, WI 54538
715-588-7660

Langlade
AVAIL, Inc
PO Box 355
Antigo, WI 54409
715-623-5177

Lincoln
HAVEN, Inc
PO Box 32
Merrill, WI 54452
715-536-1300

Manitowoc
Domestic Violence Center
PO Box 1142
Manitowoc, WI 54220
414-684-5770

Marathon
The Women's Community
PO Box 6215
329 Fourth St
Wausau, WI 54402-6215
715-842-5663

Marinette
Shelter
1530 Main St
Marinette, WI 54143
715-735-6656 or 715-732-4455

Menominee
Domestic Violence
Intervention/Prevention
(Menominee County Human Services)
PO Box 280
Keshena, WI 54135
715-799-3861

Ne-Naiah-Kaha-Kok
PO Box 82
Keshena, WI 54135
715-799-4398

West Central
Domestic Abuse Project
PO Box 700
Menomonie, WI 54751
715-235-9074

Milwaukee
Milwaukee Women's Center, Inc
611 N Broadway #230
Milwaukee, WI 53202
414-272-6199

Sojourner Truth House
PO Box 08110
Milwaukee, WI 53208
414-643-1777

Task Force on
Battered Women
4067 N 92nd St
Wauwatosa, WI 53222
414-466-1660

Oconto
NEWCAP
1201 Main
Oconto, WI 54153
414-834-4621

Oneida
Tri-County Council
on Domestic Violence
PO Box 233
Rhinelander, WI 54501
715-362-6841

Oneida Reservation
Oneida Tribe
Domestic Abuse Program
PO Box 365
Oneida, WI 54155
414-869-4415

Outagamie
Outagamie County
Domestic Abuse Program
410 E Elm
Appleton, WI 54911
414-832-1667

Ozaukee
The Advocates
414-284-6902

Pierce
Turningpoint for Victims
of Domestic Abuse, Inc
PO Box 304
River Falls, WI 54022
715-425-6751

Polk
Community Referral Agency, Inc
PO Box 365
Milltown, WI 54858
715-825-4414

Portage
CAP Services
5499 Highway 10 East
Stevens Point, WI 54481
715-345-5200

Family Crisis Center
1503 Water St
Stevens Point, WI 54481
715-344-8508

Price
Family Violence Task Force
PO Box 73
Phillips, WI 54555
715-339-4339

Racine
Women's Resource Center
of Racine, Inc
PO Box 1764
Racine, WI 53401
414-633-9913

Richland
Passages, Inc
PO Box 546
Richland Center, WI 53581
608-647-6317

Rock
YMCA Alternatives
to Domestic Violence
220 St Lawrence
Janesville, WI 53545
608-752-5445

Stateline Area
YWCA Family Shelter
608-364-1914

YMCA Family Shelter
246 W Grand Ave
Beloit, WI 53511
608-364-1964

Rusk
Time-Out Family
Abuse Shelter, Inc
PO Box 406
Ladysmith, WI 54848-0406
715-532-6976

Sauk
Hope House
PO Box 432
Baraboo, WI 53913
608-356-9123

Sheboygan
Sheboygan County
Advocates for Battered Women
1048 Janewood Lane
Sheboygan, WI 53081
414-452-7009

Safe Harbor
PO Box 582
Sheboygan, WI 53082
414-452-8611 or 414-452-7640

Taylor
TCCADA: Taylor County
Citizens Against Domestic Abuse
PO Box 224
Medford, WI 54451
715-748-5140 or 715-748-3131

Vernon
Vernon County
Domestic Abuse Project
PO Box 149
Viroqua, WI 54665
608-637-7052

Walworth
Association for the Prevention
of Family Violence (APFV)
Court House Annex
PO Box 1007
Elkhorn, WI 53121
414-723-4653

Washington
Friends of Abused Families, Inc
PO Box 117
West Bend, WI 53095
414-334-5598

Waukesha
Women's Center/Sister House
414-547-4600

Waupaca
SAFETY
PO Box 124
Waupaca, WI 54981
715-467-2273 or 715-258-6445

Winnebago
Regional Domestic
Abuse Services, Inc
PO Box 99
Neenah, WI 54957-0099
414-729-5727

Wood
Family Center, Inc
531 10th Ave N
Wisconsin Rapids, WI 54494
715-421-1511

Personal Development Center
604 E Fourth St
Marshfield, WI 54449
715-384-2971 150th

Resources for learning more about domestic violence

Seminars

In-service trainings, "Recognition and Treatment of Battered Women," can be designed specifically for your health center or hospital group. These trainings can be offered free through the Domestic Violence Health Workers Training Project, a University of Wisconsin-Madison Women's Studies Outreach Project, partially funded by the DHSS Division of Community Services, Bureau for Children, Youth and Families. To arrange a training session, write to Nancy Worcester, 623 Lowell Hall, 610 Langdon St, Madison, WI 53703.

"Making the Health System Accountable to Battered Women: Workshops for Health Workers" training workshops are offered at the Wisconsin Center, 702 Langdon, Madison, on Tuesday, Oct 6, from 6 to 9 pm, and Tuesday, Oct 27, from 8:30 to 11:30 am. These workshops are free, but advanced registration is required. To register, write to Worcester at the above address.

Videos and films

Amigas Latinas en Accion Pro-Salud--This Spanish language video includes interviews on health issues affecting Latina women. The 51-minute video includes a Violence Against Women segment on the organization Amigas Latinas en Accion Pro-Salud, nutrition and women's rights, gynecological exams and patient's rights. Rental is $40. Purchase is $60 for community groups and $150 for institutions from ALAS, 240A Elm St, Somerville, MA 02144; 617-776-4161.

Crimes Against the Future–23-minute video or film aimed at health care providers who work with pregnant women. Provides an overview of the problem of battering during pregnancy. Gives the health care provider some beginning tools for assessment and intervention. Purchase 16mm film, $150, 1/2" or 3/4" video, $60 from the March of Dimes, 1275 Mamaroneck Ave, White Plains, NY 10605; 914-428-7100.

In Need of Special Attention–18-minute emergency room training film demonstrates how emergency room personnel can identify and treat victims of spouse abuse. Film is set in an emergency room and is narrated by Loretta Swift as Nurse Houlihan from MASH. Order 16mm film, $350, or video, $310, plus $10 shipping from Select Media, 74 Varick St, Third Floor, New York, NY 10013-1019; 212-431-8923.

The Battered Women–Training films of basic information with specific versions geared for nurses, physicians and other health professionals. Contact Nora Studi, State of New Jersey Department of Community Affairs, Division on Women, Domestic Violence Prevention Program (CN 0801), 101 South Broad St, Trenton, NJ 08625-0801; 609-292-8840.

Books and manuals

Domestic Violence: A guide for health care providers–Produced by the Colorado Violence Coalition in 1991 this guide deals with the many aspects of training health care workers on battered women's issues and developing protocols, $15 from Colorado Domestic Violence Coalition, PO Box 18902, Denver, CO 80218; 303-573-9018.

Domestic Violence: A guide for health care providers–Available from the New Jersey Domestic Violence Prevention Program, this 85-page manual describes training for health care workers. Purchase for $5 from the State of New Jersey Department of Community Affairs, Division on Women, Domestic Violence Prevention Program (CN 0801), 101 South Broad St, Trenton, NJ 08625-0801; 609-292-8840.

Guidelines for Mental Health Practitioners in Domestic Violence Cases by Susan Schecter, 1987. This 24-page manual ($5) offers coverage of basic battered women's issues and guides for mental health workers. Order from the National Coalition Against Domestic Violence, 1012 14th St NW, Suite 807, Washington, DC 20005; 202-638-6388.

Why Does She Stay? What Health Care Professionals Need to Know. One of a series of guides for helping and understanding battered women, designed for social workers, employers and health professionals. Send $4.50 to the Women's Center of San Joaquin County, 620 North San Joaquin St, Stockton, CA 95202.

Protocol of Care for the Battered Women by Anne Stewart Helton, 1987. A 22-page guide for health workers to aid identification and prevention of battering *during pregnancy.* Send $5 with your order to the March of Dimes, 1275 Mamaroneck Ave, White Plains, NY 10605; 914-428-7100.

Recognition day

A 1-day recognition conference will be held Oct 20 in Madison to acknowledge Wisconsin health workers who are playing key leadership roles in getting the health system to recognize and respond to battered women. If you would like to nominate yourself or another health worker, write to Nancy Worcester at 623 Lowell Hall, 610 Langdon St, Madison, WI 53703.

A needs assessment survey of HIV-infected patients

Debra A. Murphy, PhD; G. Richard Bahr, EdD; Jeffrey A. Kelly, PhD; Barry M. Bernstein, MD; and Michael Morgan, BS, Milwaukee

Few studies have surveyed HIV-infected patients to determine how adequately medical, legal, psychological, social service, and financial needs are being met through current treatment services. Fifty HIV-infected men seen at a county medical facility were surveyed to determine which of 17 needs were being met and the importance rating attributed to those needs. Five needs were reported by more than 30% of the sample as not being met: 1) being able to talk about fears of the future, illness, or death; 2) being occupied and having things to do; 3) having up-to-date information about HIV; 4) having someone to help them with their feelings of depression, helplessness, anxiety, or anger; and 5) help for the patient's family. Three of these five needs involve better access to psychological services. Although patients felt they had knowledgeable medical staff and good health care, they wanted more up-to-date information on HIV treatment. *Wis Med J.* 1992;91(6):291-295.

PERSONS DIAGNOSED with HIV have substantial needs for services that may span a range of fields. These include medical, legal, psychological, social service, and financial needs. Although there is a consensus that HIV disease carries unique psychosocial ramifications, health care delivery systems are still struggling with what services should be offered to patients. Only a few studies have actually surveyed patients directly to determine which of their needs are being met or not being met, and—just as significantly—how important these needs are to patients.

The few studies that have directly questioned patients with HIV regarding fulfillment of their needs have varied: different needs have been investigated across studies; and different methods of exploring needs with patients have been used, with some studies using open-ended questions and others asking for ratings of importance of each need.

For example, Donlou et al[1] conducted a small cross-sectional psychosocial study of 21 homosexual or bisexual men with AIDS. Although they did not ask patients directly for ratings of perceived need, they did ask open-ended questions designed to investigate patients feelings about the disorder. The open-ended questions yielded the information that patients sought accurate, comprehensive information on medical issues related to AIDS and the opportunity to participate in support groups with other patients.

Crystal and Jackson[2] conducted a survey among 104 seropositive patients. They found that the greatest need reported among their sample was financial support. Other needs included help in keeping up with household chores and medical care that is both technically good and accessible. These investigators also reported that the majority of the respondents reported a strong but unmet need for psychological counseling.

More recently, Diaz et al[3] conducted a needs assessment in Puerto Rico of 339 patients infected with HIV. Subjects were only asked what professionals were available to them through public clinics, and which professional services would be of assistance to them. Results indicated that patients with both asymptomatic and symptomatic HIV infection felt a need to have professional assistance available from psychologists, health educators, and social workers. Specifically, 44% of the sample felt that they needed specialized psychiatric and social services, but less than 20% felt that either of these services were available in the clinics.

The current study attempted to survey a representative sample of patients with HIV infection in the Milwaukee area to determine: whether patients felt that a

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range of medical, legal, psychological, social service, or financial needs were being met, not being met, or not applicable to them; and if a need was not being met, the importance rating that subjects attributed to this need.

Methods

The patients were 50 men with HIV infection, age 18 or older, and receiving services at the Infectious Disease Clinic of the Milwaukee County Medical Complex (MCMC). MCMC serves approximately 400 HIV and AIDS patients and is currently the clinic with the largest number of such patients in the city. Subjects in this study were recruited for survey participation when they attended the clinic for regular follow-up appointments. The sample is composed of the first 50 patients who agreed to complete the survey.

The mean age of the sample was 35.7 years (SD = 7.15; range 23 to 59). Sixty percent of the sample was white, 32% was black, and 8% was either Hispanic or Native American. Mean education level was 12.8 years (SD = 2.55). Thirty-six percent of the sample was employed, 56% unemployed, and the remainder were students or retirees. Seventy percent of the subjects said they were homosexual, 12% bisexual, and 18% heterosexual. More than half of the sample reported no relationship with a significant other or reported being involved in only a short-term relationship, while 44% considered themselves to be involved in a long-term relationship. These patients believed they contracted HIV through sexual contact (75%), drug use (8%), or through unknown or undisclosed risk factors (6%). Twenty-eight percent of the sample had an AIDS diagnosis, the remainder were seropositive but asymptomatic or mildly ill. The number of months since patients had tested positive ranged from 1 to 80 (M = 31.02, SD = 23.14).

The 17 needs assessment survey items were developed through a combination of methods: previous surveys were reviewed (eg, Metropolitan AIDS Planning Project[4]); a literature review of previous surveys with HIV patients was conducted; and professionals on the research team who had previous experience working with HIV-infected patients generated items. From these sources, a list of 17 survey items were generated that covered medical, legal, psychological, social-service, and financial needs. The survey was then administered to several patients to ensure that items were easy to comprehend and to ensure standard administration of the items.

Each patient recruited at MCMC was administered the questionnaire individually, in a private room. The surveys were anonymous; the patients did not put their name or any other identifier on the questionnaire. The questionnaire was administered by a research staff member familiar with survey administration and patients infected with HIV. The surveys were administered by interviewer rather than by written questionnaire completion to preclude problems arising from varied reading levels among the population.

Results

The table shows the stem of each item on the needs assessment survey, and shows for each item: the percentage of the sample reporting that the need was not being met; and of that group of subjects that felt the need was not being met, the percentage that rated the need as "very important," "important," "somewhat important," "not very important," and "not at all important." The need assessment survey items are listed in the table in descending order based on percentage of patients reporting that a need was not being met.

As can be seen in the table, five needs were reported by more than 30% of the sample as unmet. Forty-six percent of the sample said that their need to talk about fears of future illness or death (including losses of other due to AIDS or fear for themselves) was not being met. Of the subjects that felt this need was not being met, almost all of them (95.7%) said it was an important or very important need. Thirty-six percent of the sample said that their need for being occupied and having things to do was unmet; 72.2% of these patients thought this to be a very important issue. In regard to having up-to-date information about HIV, 34% of the patients did not feel satisfied; 87.3% of this group said this was important. Support in dealing with feelings of depression, helplessness, anxiety, or anger was identified by 32% of the sample as an unmet need. Of those patients feeling they needed more support, 87.5% labeled this as important or very important. Finally, about one third of the sample reported that they needed help for family members who were having difficulty coping with the patient's HIV status; 87.6% rated this as important or very important.

Although the primary focus of this paper is on the needs that patients feel are not currently being met, it should be noted that many of the items surveyed were reported by the majority of the sample as either not applicable or as being met. For example, more than 80% of the sample said that the following needs were being met: obtaining legal advice, learning to talk about safe sex with a casual encounter, accessing social services, telling their family and past lovers about their seropositive status, being able to talk openly with clinic staff, help with problems a lover may be having dealing with the patient's disease, help in dealing with drug or alcohol use, having knowledgeable medical staff, and accessing health care. This indicates that while there are some services that need to be expanded for HIV-infected patients, there also appear to be adequate services provided for a number of issues that HIV-infected patients may face.

Discussion

There have been a number of articles that outline an approach for medical and psychosocial care for HIV-infected patients.[5-9] In addition, many opinions have been written about both the psychological issues and the social effect of the AIDS epidemic.[1,2,10,11] There have also been studies conducted to investigate such issues as social support systems and psychological status of HIV-infected patients[12,13] which help to define the needs of these patients. Few studies have, however, directly assessed patient needs. The current study attempted to address this issue through a direct patient survey.

Of the five needs that more than 30%

Text continues on page 294

Need assessment items by percent of sample who said need was not being met and rating of importance.

Need assessment item	% of Sample reporting need not being met	Very important	important	Somewhat important	Not very important	Not at all important
talking about fears of the future, illness, or death relevant to self or others	46.0	78.3	17.4	4.3	0.0	0.0
being occupied and having things to do	36.0	72.2	16.7	5.6	0.0	0.0
up-to-date information about HIV	34.0	70.6	17.6	11.8	0.0	0.0
help in dealing with feelings of depression, helplessness, anxiety, or anger	32.0	62.5	25.0	12.5	0.0	0.0
help concerning problems your family is having about your HIV status	32.0	43.8	43.8	0.0	12.5	0.0
not feeling alone or separated from others	28.0	57.1	42.9	0.0	0.0	0.0
someone to talk to about being HIV positive (eg, counselor, other HIV patients or a minister or priest)	22.0	36.4	18.2	45.4	0.0	0.0
legal advice (eg, with employer, insurance, or wills)	18.0	67.7	22.2	11.1	0.0	0.0
learning to talk about safe sex with someone you casually encounter who wants to have sex with you	18.0	33.3	33.3	11.1	22.2	0.0
access to social services (eg, home health care, homemaker services, food)	16.0	62.5	25.0	12.5	0.0	0.0
help in how to tell your family about your HIV status	16.0	12.5	25.0	25.0	37.5	0.0
help in how to talk about HIV status with past and present lovers	14.0	28.6	14.3	28.6	28.6	0.0
being able to talk openly with clinic staff about test results or medical procedures	12.0	66.7	16.7	0.0	16.7	0.0
help concerning problems your lover/ spouse is having about your HIV status	10.0	32.0	10.0	80.0	20.0	0.0
help in dealing with drug or alcohol use	10.0	20.0	40.0	40.0	0.0	0.0
sensitive, honest, knowledgeable medical staff	6.0	67.7	33.3	0.0	0.0	0.0
access to health care (eg, medical care and medication)	2.0	100.0	0.0	0.0	0.0	0.0

Contined from page 292
of the sample identified as not being met, three are related to psychological services. Almost half the patients indicated the need for opportunities to talk about fears regarding the future, their illness, and death. This was reported by most of the patients as very important to them. The second psychological need identified was assistance in dealing with feelings (eg, depression, helplessness, anxiety, or anger), and the third was help concerning problems their families had in dealing with the patient's diagnosis. These findings confirm and expand the results reported in previous surveys with seropositive persons that reported patients feeling a need for support groups,[1] or psychological counseling.[2,3]

That HIV-infected patients report a strong need to talk about their fears and that they need help in dealing with depression, anxiety, and anger is not surprising. Anxiety is one of the most common reactions to HIV seropositivity,[14] with more than 50% of homosexual men having significant anxiety, insomnia, and memory problems following their HIV diagnosis.[15] In addition, studies have found anger,[16] psychosomatic distress and physical preoccupations,[17] and depression[13] common in patients with HIV infection.

While the need for psychological services is extensive among this sample, it should be noted that these findings are similar to those reported for other patient populations with incurable disease. For example, other studies investigating the psychosocial needs of AIDS patients[18] have reported that the population was similar to cancer patients in terms of their psychological reactions to their diagnosis.

It is also not surprising that patients report a need for help for their family. As is the case with all serious diseases, significant others such as parents, siblings, spouses, lovers, and children are affected by the patient's illness, and the psychological consequences of a diagnosis are not limited to the patient. The most frequent sources of stress among family members have been fears of contracting AIDS and a sense of helplessness and grieving.[19] Fears of contracting AIDS can be alleviated by providing factual information to significant others. The often long period between initial infection and AIDS diagnosis can, however, increase feelings of loss of control among families, and these issues often need to be dealt with in psychotherapy or family counseling. In addition, families may need help in dealing with changes in patients' ability to work or care for themselves. For example, it is currently estimated that as many as 25% of HIV-infected people may have neurological changes even before the development of opportunistic infections,[20] influencing behavior, as well as cognitive and motor skills. Therapy offers care-givers an opportunity to discuss changes that are occurring in the family system and how to cope with such changes.

It should also be noted that two other needs—that of not feeling alone or separated from others and that of having someone to talk with about being HIV-positive—while reported by less than 30% of this sample as unmet, ranked as the sixth and seventh highest listings in terms of percent of the sample reporting them as unmet (28% and 22%, respectively). This confirms the need for availability of more counseling services for these patients.

It is interesting that the second most commonly reported unmet need of the sample was that of being occupied and having things to do; only 36% of the sample was employed. For patients who are unable to continue work and whose finances for transportation and activities become constrained over the course of their illness, keeping occupied appears to be a significant problem and may lead to depression and lowered self-esteem. Enabling patients to become involved—in such activities as community services, telephone "counseling" with other patients, or employment responsibilities that can be conducted from the home and on a schedule the patient sets—may reduce or prevent the need for some mental health care services for patients.

The patients surveyed were already within a health care delivery system and access to medical care was, therefore, not a problem for the majority of patients. Despite the majority's report of feeling that they had access to sensitive, honest, and knowledgeable medical staff, as well as good access to health care, the majority wanted more up-to-date information about HIV.

Many HIV-infected patients spend large amounts of time trying to obtain new information in the hope that medical breakthroughs will occur and to remain abreast of new research developments. Some type of forum in which patients have access to new findings and reports, and through which they can discourse with others, may serve to reduce anxiety. An HIV and AIDS library within infectious disease clinics, in which a clinical research trial nurse or other staff member acts as a resource person, may be useful to many patients.

In this study, HIV and AIDS patients were grouped together. It is not only possible but likely that medical, legal, psychological, social service, and financial needs change depending on the physical status of the patient. For example, patients who have been diagnosed recently may need psychological services to deal with possible denial, anxiety, depression, or anger. Patients who have been diagnosed as seropositive for a longer period of time and are more ill may, however, need more help in developing ways to occupy their time if they can no longer work, or they may need more help with financial services. In summary, the needs of HIV-infected patients are not static, but are likely to change as physical changes in the patient's health status require different coping skills. Further investigations need to be conducted to determine the specific needs of patients throughout the course of diagnosis for health care delivery systems to have in place the appropriate services.

A limitation of the current survey is that women were not included. Given the very small numbers of women being seen at the clinic, we were not able to represent them in the sample. It is possible that women with HIV infection face stressors and have needs different than men with HIV infection. Finally, although this survey involved a small sample of patients, the current findings are consistent with and expand the findings from previous

survey reports.

It is becoming progressively important to identify the varied needs of patients infected with HIV. This survey confirms results from previous studies indicating that patients often have needs that they feel are not met in their current treatment regimen. Physicians can expect that HIV-infected patients will have some of the needs discussed above, although patients may not directly ask the physician for referrals for services. Physicians should, therefore, be aware of these typical needs, and check with patients throughout stages of HIV progression to determine whether the patient requires services that are not being provided. Most particularly, the psychological needs reported among this sample emphasize the importance of providing therapy services, both for patients and their families, in an effort to improve the quality of life for individuals with HIV conditions.

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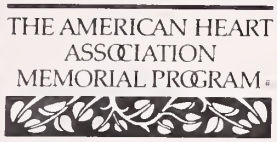

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A multi-institutional analysis of perinatal cocaine use

Annette O'Leary Quinn, RNC, MSN; Chris Van Mullem, RNC, BSN; Kathy Sturino, MD; and Fredrik Broekhuizen, MD, Waukesha

The frequency of cocaine abuse in pregnant women has increased markedly in the United States during the last decade. This increased abuse has lead to recognition of potentially negative perinatal outcomes. The purpose of this study is to determine the incidence of positive cocaine-specific screens in pregnant women and delivered infants at two Milwaukee area sites: an urban teaching hospital with a delivery base of 5,500 births annually and a suburban hospital with a delivery base of 1,700 births. A prospective, blinded analysis of urine specimens was performed at both sites over a 3-month period. All delivered infants, all women who presented to the labor and delivery unit and were discharged undelivered, and women who presented to the urban hospital's obstetrical clinic had urine samples obtained for toxicology analysis. Demographic data was also collected to include age, race, gestational age, and history of drug abuse. Results of the urine screen and demographic data were analyzed for frequency distribution. The overall incidence of positive cocaine screens was 3.5% in the urban population and less than 1% in the suburban population. *Wis Med J.* 1992;91(6):296-299.

The frequency of cocaine abuse in pregnant women has increased markedly in the United States during the last decade. This increased abuse has lead to the recognition of potentially negative perinatal outcomes such as an increased incidence of spontaneous abortions, premature rupture of membranes, preterm labor and delivery, and placental abruptions.[1,2] In the neonate, an increased incidence of neurobehavioral disturbances, intrauterine growth retardation, microcephaly, low birth weight, and sudden infant death syndrome have been documented.[2-4]

National averages of perinatal cocaine use range from 8% in subjects sampled once during pregnancy[2,5] to 17% in subjects sampled at intervals throughout pregnancy.[6] One study that used anonymous urine screening to document local incidence was performed by researchers at the Milwaukee County Medical Complex. This study tested 702 newborn infants and found a 9.3% positive rate for cocaine (Milwaukee Journal, May 27, 1990). While the rate of cocaine use in Milwaukee County had been estimated to be 11%,[7] limited data exist to support this claim. Estimates of use in areas outside of Milwaukee County have not been found in the literature.

The purpose of this study is to determine the incidence of positive cocaine-specific screens in pregnant women and delivered infants at two Milwaukee area sites: an urban teaching hospital with a delivery base of 5,500 births annually, and a suburban hospital with a delivery base of 1,700 annually. It is hypothesized that the incidence of positive cocaine screens in newborns and undelivered women at both sites will be comparable to national averages of 8% to 10%.

Methods

A prospective, anonymous analysis of urine specimens was performed at both sites over a 3-month period in 1990. The convenience sample consisted of 1,924 newborn infants and undelivered mothers who had urine screens obtained for cocaine toxicology. Cocaine use in the 48 to 72 hours prior to testing will be indicated in both the mother and neonate due the presence of benzoylecgonine, the cocaine metabolite which identifies cocaine in urine.[8] Samples were obtained from newborn infants, women who presented to the labor and delivery unit (gestational age greater than 20 weeks) and were discharged undelivered, and undelivered women who presented to the urban hospital's resident obstetrical clinic. Excluded from this sample in the suburban hospital setting were antepartum patients undergoing routine non-stress tests, oxytocin challenge tests and prostaglandin cervical ripening, because of their high likelihood of multiple testing. Demographic data was collected on each antepartum patient and each infant's mother and included age, race, gestational age, history of drug use, and the neonates birth weight.

The infant's urine was collected by an external urinary bag prior to the infant's age of 48 hours. This urine was placed in an anonymously labeled tube and sent for laboratory analysis. In the case of the undelivered mother, routine urine samples for dipstick testing were obtained on admission to the hospital or during her clinic visit, and a portion of this sample was labeled with a code and sent for laboratory toxicology screening. Neither personal identification nor demographic data was attached to the sample so that results could not be traced back to an individual mother or infant; informed consent was, therefore, not required. This study was approved by the institutional research committees of both hospitals.

All urine samples were screened for benzoylecgonine, the primary urinary metabolite of cocaine, via a competitive binding immunoassay methodology (Abbott Laboratories, South Pasadena, Calif). All positive samples were submitted for repeat testing. The results were tallied according to the code number assigned to the patient, thus preserving confidentiality and impartiality by laboratory personnel. Urine samples that tested

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positive for benzoylecgonine were analyzed for a frequency distribution to determine the incidence of cocaine use among each population and combinations of samples.

Results

The overall incidence of cocaine use was 3.5% (N=48) at the urban hospital and 0.52% (N=3) at the suburban hospital, with a combined incidence of 2.6% (N=51). Of the 1,924 samples obtained, 951 were from neonates and 973 were from undelivered mothers. In the urban hospital, there were 27 positive samples in the antepartum population; 20 were from the clinic patients and seven were from the labor and delivery unit admissions. Also in the urban center there were 21 positive samples from neonates. This represents a 3.29% positive rate in the antepartum population and a 3.98% positive rate in the infants sampled.

In the suburban hospital, there were three positive samples including two undelivered mothers and one newborn. This represents a positive rate of 1.3% in the antepartum population and a positive rate of 0.24% in the newborn population (Table).

The pattern of positive incidence of cocaine abuse correlates with the general demographic pattern of the urban and suburban hospitals. The majority of women delivering at the urban hospital were black (64.2%) and between the ages of 18 and 30 (68.6%). Of the 48 positive samples obtained at the urban hospital, 42 (87.5%) were obtained from black women. Of these same positive samples 35 (72.9%) were from subjects between the ages of 18 and 30. Twenty-six (54.2%) admitted to a history of drug abuse, but 19 (39.6%) did not admit to such a history.

The same correlation existed in the population delivering at the suburban hospital. Five hundred and twenty-eight subjects were white (95.2%). Three hundred and thirty-six were between the ages of 18 and 30 (58.3%). Of the three positive samples, all were obtained from white subjects. Two were age 31 years and one was obtained from an infant whose mother's age was 26 years. One women admitted to a history of drug abuse while the two other women denied such a history. This followed the same pattern of admitted positive histories as seen at the urban hospital. In the suburban hospital 30.3% (N=175) had a positive history of cigarette smoking. The urban hospital did not collect data on smoking incidence.

When combining the demographic data it is noted that the number of white subjects in the study were 818 (42.5%). Nine (18%) of the 51 total positives were white patients. The combined number of black subjects was 866 (45%); 42 (82%) of the total 51 positives were from black patients. There were no positive samples obtained from the other race categories.

The combined number of women between the ages of 18 and 30 was 1,261 (94%). Of the 51 total cocaine positive samples, 41 (80%) were between the ages of 18 and 30. Three hundred and forty-one (17.7%) subjects were greater than age 30, but only 8 (14% of the total 51) tested positive for cocaine use. One hundred and ninety (10%) were younger than 18, of which 2 (4% of the 51) tested positive for cocaine use. (See the figure for cocaine positive demographic comparisons.)

Discussion

The results of this study are limited in that the competitive binding immunoassay methodology detects benzoylecgonine only within 48 to 72 hours after use. This one-time sampling technique, though it is common in cocaine incidence research, is reliable within a limited time frame after use. Sampling at multiple points during the pregnancy as described by Frank et al,[6] would provide information about use over time and further help identify populations at risk.

Another limitation existed in that specimen collection was anonymous, so if a subject presented to labor and delivery more than one time, (ie, for evaluation of false labor, preterm labor, infection, etc) the potential existed for multiple urine tests from the same subject.

A factor that might account for a falsely lowered percentage rate is that pregnant drug users may have taken steps to avoid detection. Because cocaine metabolites are detectable for such a short time, if a woman were to stop using cocaine 48 to 72 hours before she delivers, urine testing for benzoylecgonine would be negative. It is also possible to drink large amounts of water to dilute the metabolite, thus making detection more difficult.[9]

While it is difficult to develop a profile of the typical pregnant cocaine user, some research has suggested that this user is likely to be 20 to 29 years of age, and have a multiparous history.[10] This research supports this profile as 80% of our positive population was between the ages of 18 and 30. The urban hospital collected parity history and found that

Positive samples obtained.

	Sample Size	Positives	Percent Positive
Suburban			
Antepartum	153	2	1.31%
Neonate	423	1	0.24%
Total	**576**	**3**	**0.52%**
Urban			
Antepartum	820	27	3.29%
Neonate	528	21	3.98%
Total	**1348**	**48**	**3.56%**
Combined			
Antepartum	973	29	2.98%
Neonate	951	22	2.31%
Total	**1924**	**51**	**2.65%**

90% of the positive population was multiparous. It is also noted that, even though less than half of the total population was black (45%), 82% of the total positive samples were from black women. This finding supports the study published in 1990 by Chasnoff, Landress and Barrett, completed in Pinellas County, Fla, that observed more frequent evidence of cocaine use in black women than in white women (7.5% v 1.8%). Chasnoff also noted that the white population had more frequent evidence of cannabis use than other substances (14.4% v 6.0% for black women). It must be noted, however, that cocaine is rarely used alone and is frequently associated with the use of nicotine, alcohol or marijuana.[11]

According to the National Institute of Drug Abuse Household Survey,[12] multiple drug use appears to be the most common drug abuse problem among women. The survey cited marijuana as the number one illicit drug of abuse, with cocaine being the second most popular. Further research is needed to examine the incidence of other substances abused in both suburban and urban populations.

While the incidence found among the combined population (2.7%, N=51) was lower than originally hypothesized, it is similar to results noted in some recent studies. For example, in 1989 the Rhode Island Department of Health attempted to collect toxicology screens on all infants born in a 17-day period. They tested 465 of 713 newborns and had a 2.6% positive rate for cocaine. The Pinellas County study by Chasnoff et al, found a 3.4% positive rate of cocaine use in both private office and public clinic patients. These studies, looking only at cocaine use, document a lower incidence than the studies cited earlier, which found rates between 8-10%.[2,5]

This study suggests that universal one-time sampling for cocaine use may not be cost effective given the relatively small number of positives in this sample and other research cited. The deleterious perinatal effects associated with cocaine abuse, however, mandate that prevention and treatment be available to these patients. So that services may be provided to drug affected families, accurate and non-judgmental screening must be done. Medical personnel need to obtain accurate histories noting such criteria as late or absent prenatal care, frequently missed appointments, family history of chemical dependency, or past reliance on painkillers or sleeping pills.[13]

Clinical signs in infants as jitteriness, coarse tremors, microcephaly, seizure of unexplained etiology, or excessive irritability should be noted.[10] When cocaine abuse is suspected, urine screening may not be enough to identify use because it is only detectable for 48 to 72 hours after use. Testing of newborn meconium may be called for because it contains more drug per unit weight of specimen when compared to urine, and remains positive for as long as 5 days after birth.[14]

Additional research looking at the use of other illicit substances in these populations would provide valuable insight for health care. Consumer education needs to include information on the negative perinatal health consequences possible with cocaine use and other abused substances.

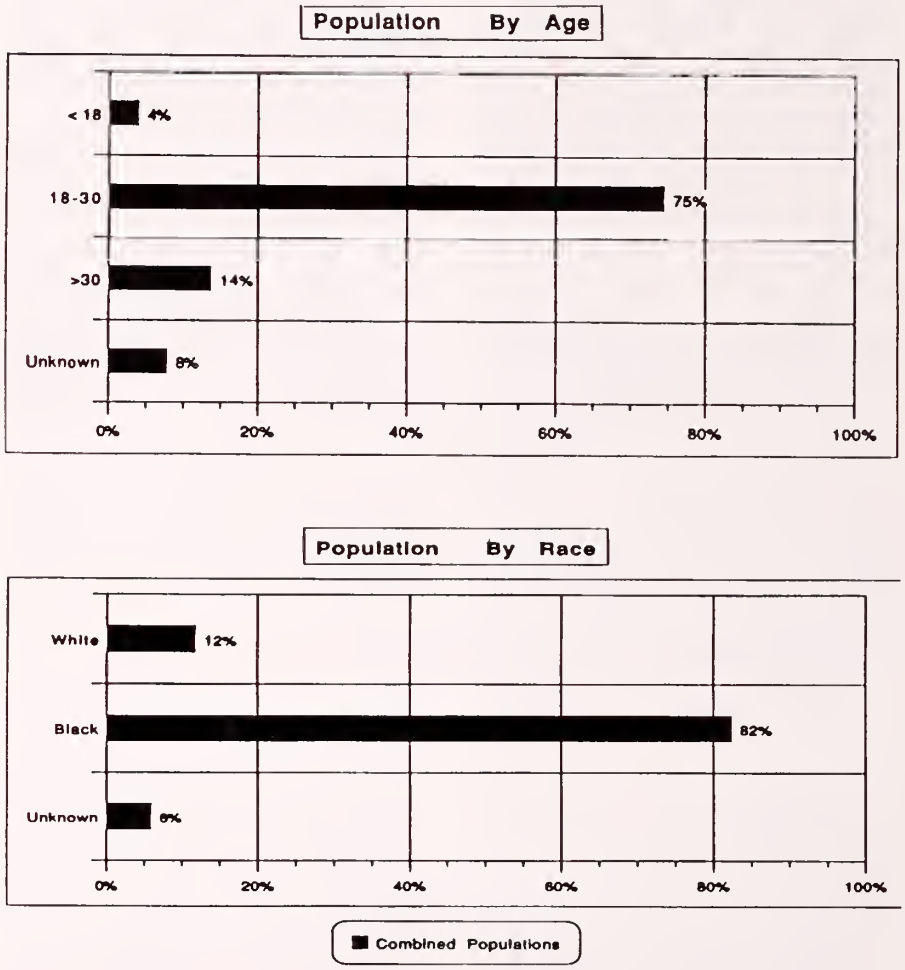

Fig.—Age and race distribution of total positive population.

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Lack of correlation between aortic calcification and bone density

Paul J. Drinka, MD; Steven F. Bauwens, PD; and Arthur A. DeSmet, MD, Madison and Chesapeake, Va

Previous radiographic studies have suggested a positive relationship between two degenerative processes associated with aging: calcification of the abdominal aorta and osteoporosis. Such a relationship has not been studied using modern quantitative densitometry. Aortic calcification was quantified on spinal radiographs from 112 elderly men. Bone mineral density was determined at six scanning sites using photon densitometry. There was no significant correlation between aortic calcification and bone mineral density at any of the scanning sites when the effect of age was held constant in the statistical analysis. *Wis Med J.*1992;91(6):299-301.

THIRTY YEARS AGO, Elkes and Berlin reported that a greater percentage of women in the seventh decade of life had calcification of the abdominal aorta than men.[1] They suggested that a positive relationship existed between two degenerative processes: calcification of the abdominal aorta and postmenopausal osteoporosis.

Bernstein, et al, studied lateral lumbar films from 1,015 ambulatory outpatient volunteers older than 45 from areas in North Dakota having high or low fluoride content in the drinking water.[2] The authors reported that subjects from the low fluoride area had lower radiographic bone density, more lumbar fractures, and a higher percentage of calcified abdominal aortas. Boukhris and Becker examined 589 lumbar films obtained in an emergency room.[3] They noted a positive correlation between aortic calcification on lateral lumbar radiographs and reduced bone density with collapsed vertebra. This relationship was maintained after statistically controlling for the effects of age.

In addition, many clinicians viewing lateral lumbar films have wondered if dense calcification of the aorta with adjacent osteopenic vertebra are somehow related. We tested the correlation between two degenerative processes of aging: aortic calcification on lumbar radiographs and bone density at multiple scanning sites in a group of elderly male volunteers.

Methods

A letter of invitation was sent to 520 men, age 65 years or older, living in Dane County, Wis, registered with the William S. Middleton Memorial Veterans Administration Hospital Outpatient Department. The letter informed the veterans that we were interested in studying bone health.

Participants were subjected to single photon densitometry of both the radial shaft and ultraradius immediately distal to the site of juxtaposition of the ulna and radius, as well as dual photon densitometry of the spine, femoral neck, trochanter and Ward's triangle.

The precision of the single photon densitometry and dual photon densitometry was 2%. Standard lateral lumbar

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films were quantitatively analyzed by a musculoskeletal radiologist who measured the length of aortic calcification overlying the 2nd, 3rd and 4th lumbar vertebra. This was accomplished by measuring the greatest superior to inferior length of aortic calcification overlying each vertebral body on the lateral radiograph. The width of aortic calcification was too thin and irregular to quantify. The maximum length of calcification possible was from the midpoint of the disk space above to the midpoint of the disk space below. If there were anterior and posterior wall calcifications, it was the total length along the vertebra that determined overlying calcification. If the calcification was not continuous, each segment of the calcification was measured and added together. For the purpose of analysis, the overlying calcification from lumbar vertebra 2 through lumbar vertebra 4 was summed.

Spearman ranked order correlations were performed between total aortic calcification and bone density at each of the scanning sites. The effect of age was held constant in the statistical analysis.

All participants were questioned regarding prior high-energy trauma with concomitant back injury. Standard lateral thoracic and lumbar films were quantita-

Correlation coefficients* between aortic calcification and bone mineral densities.

Scanning site	n	r_s	p
spine (g/cm^2)	110	-0.081	0.400
femur (g/cm^2)	106	0.042	0.672
Ward's triangle (g/cm^2)	105	-0.051	0.607
trochanter (g/cm^2)	105	-0.058	0.559
ultraradius (g/cm^2)	112	-0.150	0.117
radial shaft (g/cm^2)	112	-0.109	0.254

* Effect of age held constant.

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tively assessed. The anterior and posterior height was measured on any vertebral body that appeared to the radiologist to show a decreased anterior height relative to the posterior height. Measurements of the anterior and posterior height were made with a transparent ruler by the criteria of Lauridsen, et al.[4] The precision of this method was 1%. Vertebral bodies demonstrating irregular end plates or multiple Schmorl's nodes were excluded from measurement since these findings may reflect adolescent epiphysitis (Scheuermann's disease). Men with 25% atraumatic anterior wedging (anterior vertebral height 75% or less of the posterior height) were identified. The total calcification score for those with and without a 25% atraumatic anterior wedge deformity was compared using the Student t-test. Data on wedge deformities in this group has previously been reported.[5]

Results

One hundred twelve ambulatory men participated in the study. The group receiving the letters (N=520) had a mean age of 73.2 $\pm$ 4.6 years with a range of 66 to 96 years. The group studied had a mean age of 71.9 $\pm$ 5.8 years with a range of 66 to 91 years. When these two groups were submitted to a t-test, there was no significant difference between their ages. All but one of our study group was white.

The correlation coefficients (r_s) and level of significance (p) for each scanned site are presented in the Table. There were no significant correlations between aortic calcification and bone mineral density at any of the six sites scanned when the effect of age was held constant in the statistical analysis.

The t-test comparing total aortic calcification overlying lumbar vertebra 2 through lumbar vertebra 4 in those with (N=12) and without (N=100) 25% atraumatic wedge deformities showed no significant difference (t=0.72, p=0.474).

Discussion

There was no significant correlation between aortic calcification and bone mineral density at any of the scanning sites or between aortic calcification and atraumatic wedge deformities. The lack of correlation between dual photon densitometry of the lumbar area and the linear extent of calcification overlying lumbar vertebra 2 - lumbar vertebra 4 is especially significant since the overlying aortic calcification actually contributes slightly to the lumbar density measurement. We were unable to substantiate the 30-year-old observations made by investigators using plain radiographs.

There was no relationship between the quantitative measure of aortic calcification and bone mineral density in these elderly male volunteers. The previous observations may be related to the well-known separate associations between age and two degenerative processes. Our findings remain to be confirmed in a female population. We have reconfirmed observations made by Anderson, et al, in 1964, who found no relationship between radiographic osteoporosis and calcification of the abdominal aorta.[6]

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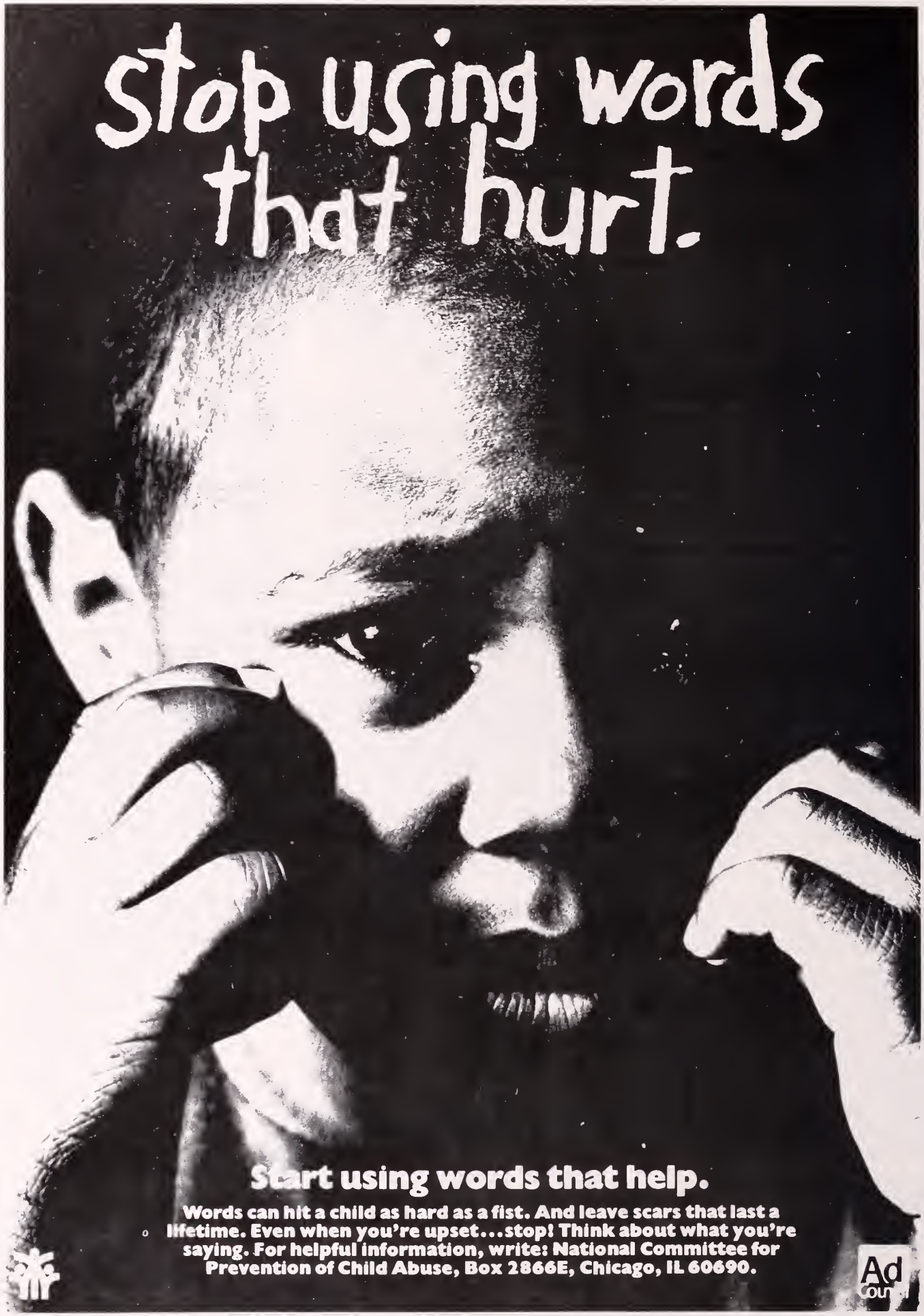

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Public health

Increasing incidence of end stage renal disease in Wisconsin: 1982-1990

Betsy Sleath, MS, RPh, and Patrick Remington, MD, Madison

End stage renal disease (ESRD) is an important public health problem. The number of people being treated for ESRD in the United States has steadily increased from 10,000 in 1973, when the Medicare ESRD entitlement became effective, to nearly 150,000 in 1991.[1] The cause of this increase is not known, but may be related to increases in the true incidence of ESRD, to increased treatment of persons with ESRD, or to both. In this paper, we examine trends in the incidence of treated ESRD in Wisconsin between 1982 and 1990.

Methods

The data were obtained from the Renal Network of the Upper Midwest (ESRD Network 11). These data included all newly diagnosed patients who began a course of treatment for ESRD (in-center dialysis, home dialysis, or transplantation) in Wisconsin from 1982 through 1990.[2] Incidence rates are expressed per

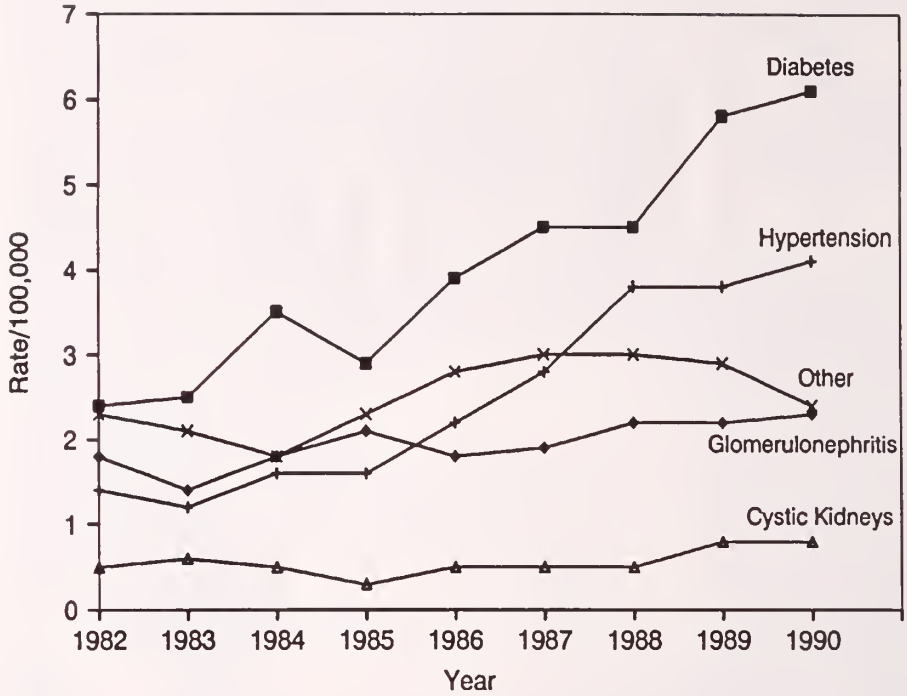
Continued on next page

Trends in the incidence rates of treated ESRD in Wisconsin per 100,000 population by sex, age, and race, 1982-1990.

	1982	1990	Relative change
Total	8.4 (400)	15.6 (764)	1.9
Sex			
Women	7.4 (177)	14.1 (353)	1.9
Men	10.1 (223)	17.1 (411)	1.7
Race			
White	8.0 (353)	14.1 (632)	1.8
Black	21.3 (39)	37.2 (91)	1.7
American Indian	20.5 (6)	53.0 (20)	2.6
Age			
< 45	5.1 (164)	5.3 (177)	1.0
45-59	15.3 (104)	25.0 (171)	1.6
60-64	16.4 (34)	46.1 (96)	2.8
65-74	21.5 (71)	53.8 (193)	2.5
75+	11.5 (27)	43.3 (127)	3.8
Primary Diagnosis			
Diabetes	2.4 (114)	6.1 (297)	2.5
Hypertension	1.4 (67)	4.1 (199)	2.9
Glomerulonephritis	1.8 (86)	2.3 (113)	1.3
Cystic Kidney disease	0.5 (23)	0.8 (37)	1.6
Other	2.3 (110)	2.4 (118)	1.0

( ) = number

The public health series is not reviewed by the *WMJ* Editorial Board. Betsy Sleath, a Robert Wood Johnson/AFPE fellow, is a PhD candidate at the University of Wisconsin-Madison and a clinical pharmacist on the renal transplant unit at the University of Wisconsin Hospital and Clinics. Dr Remington is with the Bureau of Public Health, Wisconsin Division of Health. Address reprint requests to Patrick Remington, MD, Wisconsin Division of Health, 1400 E Washington Ave, Madison, WI 53703-3041. Copyright 1992 by the State Medical Society of Wisconsin.



Trends in the incidence of treated end stage renal disease (ESRD) treated in Wisconsin, by primary etiology, 1982-1990.

Continued from preceding page
100,000 population and were calculated based on 1980 and 1990 population data from the US Census and yearly population estimates from the Demographic Services Center of the Wisconsin Department of Administration.[3]

Results

The overall incidence rate of treated ESRD in Wisconsin nearly doubled between 1982 and 1990, from 8.4 to 15.6 per 100,000 population (Table). The increase was slightly greater for women than for men.

The incidence of treated ESRD increased for all races over the nine year period (Table). The incidence of ESRD tripled among American Indians between 1982 and 1990 from 20.5 per 100,000 population to 53 per 100,000 population. The incidence of treated ESRD nearly doubled among both blacks and whites between 1982 and 1990. Compared with whites, however, blacks and American Indians had more than twice the incidence of treated ESRD in both 1982 and 1990.

The incidence of treated ESRD in Wisconsin increased the most among those individuals 60 years old and older (Table). The incidence for those individuals between the ages of 60 and 74 more than doubled between 1982 and 1990. The incidence for those individuals age 75 and older more than tripled from 11.5 per 100,000 population to 43.3 per 100,000 population.

The figure shows the incidence rates of treated ESRD by primary etiology. Diabetes had the highest incidence rates for all 9 years. The incidence rates for ESRD due to diabetes and hypertension almost tripled between 1982 and 1990 while the incidence rates for ESRD due to glomerulonephritis, polycystic kidney disease, and all other causes changed little over the 9-year period. By 1990, diabetes and hypertension accounted for 65% of all new cases of treated ESRD in Wisconsin.

Comment

The incidence of treated ESRD increased nearly two-fold in Wisconsin over the past 10 years. About 85% of this increase resulted from increased treatment for persons with ESRD caused by diabetes or hypertension. Several studies that examined the increasing incidence of treated ESRD in different patient populations during the 1970s and 1980s found that hypertension and diabetes had become the two major causes of newly treated ESRD over time.[4-6]

Almost two thirds of the increase resulted from increased treatment among persons 65 years old and older. This greater increase among the elderly may reflect increased likelihood to place these patients on dialysis, since the services are paid for by many sources, including Medicare, Medicaid, and the Wisconsin Renal Program.

It is possible that there has been an increase in the true incidence of ESRD. For example, the improved medical treatment of diabetes and hypertension may have decreased competing mortality (eg,

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from coronary artery disease), and therefore increased the number of patients who survive and eventually develop ESRD.[6] There have not been, however, increases in treated ESRD among the young nor for kidney diseases due to glomerulonephritis or other diseases.

The trends in ESRD are disconcerting, especially given the need to control health care costs. Currently, the cost of maintaining a patient on long term dialysis is about $32,000 per year and the cost of a kidney transplant is about $56,000.[1] Using these national cost estimates and prevalence data on the number of patients receiving dialysis and transplants in 1990, we estimated that about $66 million was spent on Wisconsin ESRD patients in 1990. Also, ESRD adversely affects the patient's quality of life, since most usually end up on dialysis or immunosuppressive therapy for the rest of their lives.

End stage renal disease could be avoided in many patients through the prevention and management of some of the major underlying causes of the disease. Physicians can help prevent ESRD by helping patients properly manage and control their diabetes and hypertension before they develop into even further disabling diseases like ESRD.

Acknowledgements
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Legislative wrap-up: 1991-1992

During the 1991-1992 legislative session, the SMS lobbied aggressively on scores of bills, while reviewing and taking positions on many more. This report provides a summary and status report on many of the session's bills in which SMS had an interest. Should you wish more information on these or any other legislative issues, please feel free to contact Mike Kirby, director of the SMS Division of Public Affairs, or Don Lord, manager of SMS government relations at (608) 257-6781 or 800-362-9080.

Health care reform

Small employer health insurance. SB 341, AB 331, and AB 655 were introduced to establish basic benefits health insurance plans for employees of employers of two to 25 persons. AB 91, the biennial budget bill, also included a small business health insurance proposal, which was dropped due to problems with some of the specifics. Ultimately, a plan was approved by both houses in AB 655. Under AB 655, all insurers selling insurance to small groups would have to offer the basic plan, and would have to accept all applicants, regardless of medical condition or claims experience. AB 655 was enacted as 1991 Wisconsin Act 250. The SMS actively sought legislation creating the Small Employer Health Insurance initiative.

Insurance rate reform. Related to the above, AB 91 contained a provision that establishes insurance rate stabilization reform for all group plans covering employees of small businesses. Those rate reforms and premium limitations will prohibit cancellation or exorbitant premium increases as a result of an employee's medical claims experience. This provision was enacted in 1991 Wisconsin Act 39. The SMS supported this reform.

Capital expenditure review program. A conference committee appointed on AB 655 added a number of cost containment initiatives that were not considered in either the Assembly or Senate's initial deliberation on AB 655. Foremost among the conference committee's recommendations was the re-creation of a capital expenditure review (CER) program. Effective July 1, 1993, a three-member cost containment commission must review and approve the following, except for projects where legally enforceable contracts are already in place before July 1, 1993:

- capital expenditures by a hospital exceeding $1 million;
- new hospital services exceeding $500,000;
- expenditures by hospitals or by medical practices for clinical medical equipment exceeding $500,000;
- acquisition of a hospital; or
- construction or operation of an ambulatory surgery center or home health agency.

Between Oct 1, 1992, and the July 1, 1993, implementation date of CER, hospitals or other providers must conduct a health care project analysis and hold a public hearing before any of the above projects may be implemented, unless a legally enforceable contract was in place before Oct 1, 1992. Conference committee reports are not amendable, so CER remained intact with the passage of AB 655. The bill became 1991 Wisconsin Act 250. The SMS opposed reinstatement of CER.

Other health care cost containment. The AB 655 conference committee also included in its report other measures aimed at cost containment, as follows:

- until July 1, 1996, establish a moratorium on additional psychiatric and AODA beds;
- direct the DHSS to investigate the concept of rural medical centers established for purposes of coordinating health care services in rural communities;
- prohibit health care providers from reducing or waiving copayments or deductibles contained within health insurance policies, except in cases of financial hardship;
- double to $2,000 the outpatient minimum coverage for treatment of mental illness and AODA, and add coverage for transitional treatment arrangements, without increasing the combined minimum coverage required for both inpatient and outpatient treatment;
- allow health care providers to obtain a certificate of public advantage to pursue mergers, joint ventures, and sharing of services or equipment under the "state interest" exemption to antitrust restrictions;
- until July 1, 1996, establish a moratorium on construction of new hospital beds; or
- require hospitals which increase rates above the CPI to hold a public hearing and to release information from those hearings to the OHCI;
- direct the insurance commissioner to establish a standardized billing form, insurance claim form, and explanation of benefits form and require providers and insurers to use these forms, effective July 1, 1993;
- direct the insurance commissioner to establish, inclusive of confidentiality protections, a uniform patient identification system to be used on standardized billing and claim forms;
- require the OHCI to develop a uniform accounting system for hospitals and require hospitals to implement the system in the first fiscal year commencing after July 1, 1993;
- create a cost containment council to advise and report to the cost containment commission on various health care issues, including development of a state health plan; and
- create a task force on health care cost containment consisting of legislative leadership and administration representatives, to make further recommendations on health care costs and access by Jan 1, 1993.

All of these items were adopted with the passage of the unamendable conference committee report on AB 655. The SMS supported the first five items, which were included in the the 12-point plan created by the SMS, Wisconsin Manufacturers & Commerce, and Wisconsin Hospital Association, but did not support or took no position on most of the other items. These provisions are contained in 1991 Wisconsin Act 250.

Health insurance for low-income residents. SB 465 and AB 892 were introduced to provide low-income persons with health insurance under a state operated plan. Enrollees of the plan would pay annual premiums and copayments, with the amounts determined by income level. Reimbursement rates under the plan would be determined through negotiation with providers. The bills also would establish a health care development grant program for funding construction or expansion of primary health care centers. Both bills died in committee.

Universal health plan. SB 521 and AB 555 were introduced to create a single-payer, publicly funded health plan to cover all health care services for all Wisconsin residents. The bill establishes a health policy board charged with developing policy on revenue sources and provider reimbursement. AB 555 was reported out of committee on a vote of 8-3 but died in the Joint Finance Committee. SB 521 died in Senate committee.

Hospital rate-setting. SB 471 and AB 883 were introduced to reinstate hospital rate-setting in Wisconsin. Similar to the program which terminated July 1, 1987, the bills establish a three-member rate-setting commission responsible for regulating rates hospitals may charge to non-government payers. Each bill was subsequently amended to add a CER program. SB 471 received a favorable committee recommendation, but it was not scheduled for Senate debate. AB 883 died in committee. The SMS opposed reinstatement of rate-setting and CER.

Health care technology review. AB 907 would have established a requirement for local public hearings on health care projects involving significant capital expenditures, addition or expansion of services, or acquisition of new technologies identified by a state board. There would be no regulation of a health care provider's decision to undertake a project. The SMS supported the bill, which reflects one of the elements of the SMS/WMC/WHA 12-point plan. The bill died in committee, although the local public hearing requirement was added to AB 655 to apply until the implementation of CER in 1993.

Health insurance

HIRSP reimbursement reduction. SB 483 included a provision sought by insurers that will reduce payments to health care providers by 10% under the Health Insurance Risk Sharing Plan (HIRSP). HIRSP provides health insurance coverage to persons considered high risks in the insurance market. The program consistently runs a deficit which has increased substantially in recent years. Health insurance carriers are assessed to fund the deficit and seek to shift some of the program's costs to other revenue sources, as well as cutting program costs. Language giving the HIRSP authority to cut rates

unilaterally was added in the Senate, but deleted in the Assembly; the conference committee then inserted the 10% reduction. The SMS actively opposed this provision and similar HIRSP provisions. The SMS requested that the governor veto the reduction, but it was approved and is now a part of 1991 Wisconsin Act 269.

Insurance coverage related to diabetics. Temporary laws were enacted and reenacted during the 1980s to require health insurance policies to cover expenses incurred for the installation and use of insulin infusion pumps or other equipment and supplies in the treatment of diabetes, and to cover expenses incurred for diabetic self-management programs. The existing law is scheduled to terminate at the end of 1992. Legislation was passed in AB 286 to make these insurance requirements permanent. The bill became 1991 Wisconsin Act 45.

Newborn insurance coverage. AB 427 requires health insurance coverage for newborn children in instances where a parent is covered by a single coverage policy. Existing law applies this requirement only to family coverage policies. The SMS supported the bill. It became 1991 Wisconsin Act 123.

Acupuncturist insurance coverage. AB 451 would have required health insurance coverage for diagnostic and treatment services performed by an acupuncturist in any policy that covers diagnostic and treatment services performed by a physician. This bill was defeated in the Assembly on a roll call vote. The SMS opposed the bill.

Insurance assignment. AB 607 would have required a health insurer to pay health care providers directly, rather than the insured, where the covered person makes a written assignment of benefits payable under the policy. The bill, which was supported by the SMS, died in Assembly committee, but its provisions were included in the budget adjustment bill (SB 483) and then vetoed by the governor.

Breast cancer treatments. AB 909 would have required health insurance policies that cover inpatient hospitalization to provide coverage for high-dose chemotherapy and also bone marrow transplants for the treatment of breast cancer. The bill died in Assembly committee.

Genetic tests for insurance purposes. An amendment to SB 483 prohibits health and life insurers from requiring an individual or a member of the individual's family to submit to a genetic test for coverage purposes. Health insurers would further be prohibited from requiring individuals to reveal whether they or family members have had a genetic test, and from requiring the individuals to reveal the results of those tests. The provision is contained in 1991 Wisconsin Act 269. The SMS supported this provision.

Dental services insurance coverage. An amendment to SB 483 requires health insurance policies that provide coverage of any diagnostic and treatment procedure when performed by a physician to also cover the procedure when performed by a dentist. The provision was approved in 1991 Wisconsin Act 269.

Endometriosis insurance coverage. An amendment to SB 483 would have required group health insurance policies that provide maternity coverage to include coverage for the treatment of endometriosis including infertility treatment. The governor vetoed this requirement.

Medicaid and Medicare

Physician Medicaid reimbursement. With the Legislature's approval of AB 91, Medicaid reimbursement for physicians was increased as follows:

- increase reimbursement rates for all physicians by 1% effective July 1, 1991, and by 2% effective July 1, 1992;
- increase reimbursement for obstetric services from 65% to 70% of average charges effective July 1, 1992 and to 75% effective Jan 1, 1993;
- increase reimbursement for pediatric services from 60% to 65% of average charges effective Jan 1, 1992 and to 70% effective Jan 1, 1993;
- increase reimbursement for physician office visits to 65% of average charges effective July 1, 1992;
- provide for a 10% bonus effective Jan 1, 1992, for primary care services provided in, or to residents of, a health professional shortage area (HPSA).

The governor approved these increases for the first year of the biennium but placed the second-year increase on hold when second-year Medicaid funding was vetoed. SB 483 restored all the AB 91 increases with the exception of the increase for physician office visits, which is delayed until July 1, 1993. Also contained in SB 483 is a provision sought by the SMS that requires HMOs to pass 100% of the HPSA bonus to physicians providing the service. These items were enacted in 1991 Wisconsin Act 269. The SMS was actively involved in deliberations on both budget bills seeking to obtain reasonable physician reimbursement in the Medicaid program.

Rock County HMO initiative. SB 483, as introduced, included an expansion of the Medicaid HMO initiative to Rock County. The SMS obtained an amendment to prohibit this expansion of the HMO initiative and direct DHSS instead to establish a primary provider case management pilot for Rock County. (Under such a system, each patient designates a primary care physician who then provides or authorizes all other care to the patient. Normal MA reimbursement and a separate case-management fee is provided to the primary provider.) The governor vetoed this amendment from SB 483, but indicated that the DHSS would consider using the primary provider model instead of, or in addition to, mandatory Medicaid HMO enrollment in Rock County.

MA services council. The Joint Finance Committee added a provision to SB 483 to create an 11-member Medical Assistance services council, attached to the DHSS, for purposes of seeking recommendations on methods to improve the cost effectiveness of the MA program and access to the program. The governor vetoed creation of this council.

PAIRS program repeal. As a result of a critical review of the program by the Legislative Audit Bureau, the budget adjustment bill, as passed, contains a provision to repeal the Medicaid psychiatric and AODA inpatient review system (PAIRS). The audit bureau's review found that payments to WIPRO under PAIRS far exceeded the money saved. The repeal was approved in 1991 Wisconsin Act 269.

Medicare assignment. AB 837 would have mandated that physicians accept assignment on all Medicare patients. The authors later proposed amending the bill to mandate assignment only for those at or below the Homestead income level ($19,154). The SMS succeeded in keeping the bill in committee.

PartnerCare enrollment. In the 1989 legislative session, the SMS was instrumental in converting the mandatory Medicare assignment legislation into a bill which, in effect, markets PartnerCare through the Department of Revenue. As a result of that legislation, the Department of Revenue issues PartnerCare enrollment cards to persons 65 years or older who qualify for the Homestead Tax Relief Program at its 1989 income threshold of $18,000. Since that time, the income threshold for Homestead eligibility has increased to $19,154. Legislation (SB 396) was introduced to establish, on a continuing basis, that eligibility for the PartnerCare enrollment mailing be set at the same income threshold as that established for Homestead. The bill was approved by both houses and was signed by the governor in 1991 Wisconsin Act 232. The SMS supported the bill.

Healthy Start program. A variety of bills were introduced to increase the income eligibility threshold for the Healthy Start program. The program extends Medicaid coverage for low-income pregnant women and children up to age 6. The biennial budget bill raised eligibility to 155% of the poverty level. A provision in SB 483 would have expanded Healthy Start coverage to pregnant women and children under the age of 1 in families with incomes up to 165% (or 185% if a federal wavier is granted) of the poverty level, as of July 1, 1993. The governor vetoed the SB 483 expansions because he felt the spending commitments should be made by the next Legislature during its consideration of the 1993-1995 biennial budget bill. The SMS generally supports the expansion of Healthy Start, along with efforts to increase physicians' reimbursement and remove administrative barriers.

Liability

Non-economic damages. SB 136, SB 458 and AB 1022 would have established a cap on non-economic damages in medical liability cases. Additionally, the governor included a $1 million cap on non-economic damages in both of his budget bills. The Joint Finance Committee removed the cap during its deliberations on each budget bill, and none of the introduced bills received serious consideration before dying in committee. The SMS policy supports a $250,000 cap on non-economic damages.

Wrongful death awards. Current law authorizes damages for pecuniary injury from wrongful death to any person entitled to bring a wrongful death action. Additional damages not to exceed $50,000 for loss of society and companionship may be awarded to a close relative of the deceased. Legislation was narrowly passed in AB 388 to increase this loss of society and companionship cap to $150,000. Efforts to amend the bill to clarify the applicability of the limit to medical malpractice cases were ruled non-germane. The SMS opposed raising this cap, particularly without clarifying the definition, and requested the bill be vetoed. The governor, however, approved the bill as 1991 Wisconsin Act 308.

Joint and several liability. A number of bills were introduced to modify the legal rule of joint and several liability. Under most of the bills, a party who contributes to an injury would be limited to his or her proportionate share of comparative negligence. A plaintiff may currently collect total damages against any individual who was a party to the injury, even when the individual's comparative negligence was very minor. None of the bills were released from committee.

Volunteer provider program. AB 380 expands the volunteer health care provider program, which is currently piloted in Brown and Racine counties, to Milwaukee County. The bill also expands the list of health care providers so that all regulated health care providers are eligible for participation in the program. Under the current program, physicians, nurses, dentists and optometrists are afforded state liability protection for volunteer services rendered at non-profit free clinics, if currently receiving no income from the practice of the health care profession. While AB 380 did not pass, its provisions were incorporated into the budget adjustment bill (SB 483). Also, a related provision in SB 483 extends state liability protection to physicians and nurses who volunteer services at a medical clinic operated by the Salvation Army in Outagamie County. The governor approved the geographic expansions of this program but vetoed expanding the program to cover additional types of providers. The SMS supported expansion of the volunteer provider program to additional counties.

Team physician immunity. AB 591, AB 610, and AB 628 were introduced to provide "good Samaritan" immunity to physicians volunteering care to participants in school or youth athletic events. AB 591 was modified in committee to require the Patients Compensation Fund to provide first-dollar coverage in liability cases involving a team physician, in lieu of granting immunity. The SMS was successful in returning the bill to its original state before it overwhelmingly passed the Assembly. The bill was then altered in Senate committee to again remove the immunity protection, and instead, extend state liability protection to physicians whose liability insurance does not cover voluntary team physicians. It passed the Senate in that state. The Assembly, however, refused to take up the modified bill in the session's final days, and so it died as a result. The SMS supported immunity

for team physicians.

Fund fee assessments. AB 549 would have lowered the base coverage limits for the Patients Compensation Fund and eliminated assessments for the fund for physicians practicing in medical shortage areas. To ensure that the fund is sufficiently funded, assessments on physicians outside the shortage areas would increase. The bill died in committee. The SMS opposed the bill.

Patients Compensation Fund fees. AB 614, developed by the Legislative Council's Special Committee on Prenatal Care, would have provided for a 50% fee reduction in the PCF for physicians providing obstetric or pediatric care whose caseload is at least 25% Medicaid or charity care. The fund fee reduction would be subsidized by increases in other PCF fees. The bill died in committee. The SMS supports state subsidies for physicians with high Medicaid, Medicare, or uncompensated care caseloads, but only if those subsidies are provided with state funds, not at the expense of other physicians.

Damages related to experimental treatment. AB 839 would have prohibited punitive damage awards in medical malpractice actions for injuries related to the use of drugs or devices that have not yet received federal approval, when the patient's condition is life-threatening and the patient gives informed consent. The bill was sought by AIDS patients and others seeking greater access to experimental drugs, but was opposed by the Wisconsin Academy of Trial Lawyers. Due to that opposition, the authors agreed to an amendment which, instead of restricting punitive damages related to experimental treatments, required the PCF to provide first-dollar coverage for the punitive damages. The fund does not currently provide protection for any punitive damages. When the bill reached the floor for debate, an attempt to return to the original version resulted in the authors' tabling their own bill. The SMS supported the original bill and opposed the PCF coverage amendment.

Immunization program, physician liability. SB 483 was amended to include a provision that extends state liability protection to physicians who volunteer their services in supervising local public health vaccination programs. The governor approved this provision in 1991 Wisconsin Act 269. The SMS sought this amendment to SB 483 in the wake of an attorney general's opinion that these physicians were not agents of the state.

Health regulation

Medical service corporations. Under current law, only persons licensed, certified or registered in the same field of endeavor may organize and become shareholders, directors or officers in a service corporation (ie, only physicians may be partners with other physicians). Legislation was sought to modify this law to allow optometrists, podiatrists, nurses, chiropractors, psychologists, and some other health professionals to become partners, officers or directors in physician service corporations. The SMS opposed this change, as it would have created a major new liability for the PCF and raised substantial ethical and quality-assurance concerns. AB 645 died in committee. Although it was added to SB 483 at two points, the SMS succeeded in deleting it from the bill.

Patient record copying fees. SB 483 contains a provision directing the DHSS to establish, by rule, uniform fees that a health care provider may charge for patient records requested by attorneys for legal proceedings. The new fee structure will replace current law (imposed on most providers by the Wisconsin Supreme Court) which limits the fee to $5 per request, or 10 cents per page and $2 per x-ray copy, whichever is greater. The governor approved this change in 1991 Wisconsin Act 269. The SMS sought this modification to the Supreme Court's imposition of the restrictive fees.

Medical resident work hours. SB 139 would limit the hours medical residents or interns could spend in training. It would prohibit training hospitals from scheduling residents or interns for more than 80 hours per week and for more than 24 consecutive hours at a time, and would require 24 consecutive hours of non-working time per week. The SMS opposed SB 139. It died in Senate committee.

Out-of-state MD orders. The Senate Health Committee introduced SB 269, which authorizes nurses to accept orders from physicians licensed outside Wisconsin whose patients are in need of continuing care and treatment in Wisconsin. The bill primarily intends to address situations in Wisconsin's border communities where persons see physicians from an adjacent state and are in need of home health care services. The SMS supported the legislation. The bill was enacted in 1991 Wisconsin Act 181.

Burn injury reporting. Legislation was introduced in various proposals which would require physicians and other health care providers to report to local law enforcement all those patients who have sustained second- or third-degree burns covering at least 5% of the body. Swelling of the larynx or burn to the upper respiratory tract would also be reportable if it is due to inhalation of superheated air. The legislation was requested by the attorney general's office under the theory that it may be helpful in assisting arson investigations. The provision was inserted in the biennial budget bill (AB 91), but the SMS succeeded in amending the provision to require such reporting only if there was reasonable cause to believe the burns were incurred as the result of a crime. That amendment became law in 1991 Wisconsin Act 39.

Patient records. A provision inserted in SB 483 requires health care providers, or a personal representative in the case of a deceased solo practitioner, to provide notice concerning the maintenance or destruction of any patient records in the provider's possession when the provider ceased business or died. Written notice by mail or newspaper ad must inform patients where the records will be maintained, or when and where the records will be destroyed unless retrieved by the

patient. The proposal is not intended to affect patient records that are institutionally maintained such as in a clinic, hospital or nursing home.

This provision originated out of the Legislative Council's Special Committee on Privacy and Information Technology and is much more limited in scope than a previous Committee proposal–opposed by the SMS–that contained more onerous patient notification requirements concerning patient records. The provision in its current form generally reflects current SMS legal advice on disposition of patient records. The governor approved this provision in 1991 Wisconsin Act 269.

Rx expiration date. SB 462 and AB 926 were introduced to require that the label attached to prescription drug containers include the expiration date of the prescribed drug. Neither bill passed.

Patient records informed consent release. SB 483, as recommended by the governor, restores two elements of previous law for the informed consent release of patient records. The type of information to be disclosed and the types of health care providers making the disclosure are returned as specified items on the written informed consent. These provisions inadvertently disappeared in AB 91 when the governor's vetoes encompassed more than was targeted. These restorations were approved in 1991 Wisconsin Act 269. The SMS supported return to previous law.

Physician discipline. AB 1086 was intended to strengthen the physician discipline role of the Medical Examining Board (MEB). Specifically, the bill would:

- authorize the MEB to assess forfeitures of not more than $25,000 against physicians for willful misconduct, which would be defined by MEB administrative rules;
- provide that judicial proceedings to appeal MEB disciplinary decisions shall be held in Dane County Circuit Court, instead of the circuit court in which the physician resides;
- prohibit the circuit court, during its review of a case, from suspending or staying a disciplinary decision of the MEB unless specified conditions are met; and
- authorize additional staff positions in the Department of Regulation and Licensing whose responsibilities would be dedicated solely to the physician review and discipline activities of the MEB (the positions would be funded through increased physician licensure fees).

The bill died in Assembly committee. Several of its provisions reflect SMS policy on the funding and operation of the MEB.

Public health

Alcohol menu disclosure. SB 510 and AB 966 require restaurants that use alcohol beverages in food preparations to specifically indicate on the restaurant menu the food items that contain alcohol. Both bills died in committee.

Mental commitment standard. AB 203 was introduced to create an additional standard for involuntary mental health commitment. Most often described as the "fifth standard," the bill authorizes commitment proceedings, subject to existing due process requirements, based on a person's need for treatment. This standard serves as an alternative to existing standards which require evidence of dangerousness. The Assembly passed a modified version of the introduced bill that limited commitment subjects under the new standard to persons with a treatment history. The bill later died in Senate committee. The SMS supported the legislation.

Statewide poison control system. Legislation to establish an effective statewide poison control system was introduced in AB 378. The bill requires the DHSS to designate no more than two regional poison control centers responsible for providing emergency information, education outreach and data analysis. State appropriations and matching contributions fund the system. The bill received unanimous approval in Assembly committee before it died in the Joint Finance Committee. The SMS supported the bill.

Lead poisoning prevention. AB 441 would establish a grant program within the DHSS to provide funding for programs to detect lead poisoning or lead exposure, to provide education about the health dangers related to lead exposure and to provide for the abatement of lead in housing. Approximately $3.3 million would be provided for grants to local public health departments, the bulk of which is earmarked for the city of Milwaukee. The SMS supported AB 441 without position on the funding allocation formula. The bill received approval in Assembly committee, but died in the Joint Finance Committee.

Teen pregnancy prevention. A Legislative Council Special Committee produced companion bills (SB 324 and AB 630) that contained a variety of provisions focusing on teen pregnancy prevention and maternal and child health, including funding for school-based or school-linked comprehensive health clinics. The SMS supported development of programs to address the primary health care needs of the adolescent population, including those located in schools. Both bills received committee approval, but later died in the Joint Finance Committee.

Newborn screening. Current law requires physicians, before discharge from a hospital, to subject newborns to blood tests for disorders specified by statute and also for disorders specified by the DHSS. AB 774 removes the statutory list of disorders and instead authorizes the DHSS to determine the types of metabolic and congenital disorders for which tests are required. The DHSS will use a medical advisory committee to evaluate the state's infant screening programs and make changes to the list of required tests as appropriate. The SMS supported the bill. The bill was enacted as 1991 Wisconsin Act 177.

Rural breast cancer screening program. Currently, funds are provided by the DHSS to administer breast cancer screening services to women in 12 specified rural counties. Legislation was introduced in AB 961 to authorize the DHSS to

designate by rule the 12 rural counties with the highest incidence of late-stage breast cancer as the counties that will receive grants under this program. The bill also appropriates funds for the development and distribution of educational materials relating to breast cancer in rural areas. SB 483 was amended to include these provisions. The governor approved these changes in 1991 Wisconsin Act 269.

Public safety

Seat belt use. SB 7 and AB 15 were introduced to repeal the June 30, 1991, sunset date on the law requiring motor vehicle operators and passengers to use seat belts. A permanent law has now been established for required seat belt use with the passage of SB 7. It became 1991 Wisconsin Act 26. The SMS has been a longtime supporter of a permanent seat belt law for Wisconsin.

Handgun purchases. Several bills were introduced to restrict the sale of handguns. AB 179 prohibits a licensed firearms dealer from selling a handgun until 48 hours have elapsed from the time the firearms dealer notifies and receives clearance from the attorney general's office concerning the customer's criminal background check. That bill was enacted as 1991 Wisconsin Act 11. The SMS policy for handgun purchases, as adopted by the House of Delegates, supports conducting a mandatory criminal history background check and a 7-day waiting period.

Operating while intoxicated. This session more than 12 bills were introduced aimed at strengthening the OWI laws and their penalties. SB 308, as introduced, proposed to lower the allowable blood alcohol concentration (BAC) from .10 to .08. As passed by the Legislature, however, the proposal was primarily converted into a repeat offenders bill. It establishes .08 BAC for offenders subsequent to a second OWI conviction. Judges would be empowered to confiscate vehicles or require ignition interlock devices on vehicles of repeat offenders. The bill also extends the absolute sobriety law to OWI offenders who have been issued occupational licenses. While the SMS supported the enacted legislation, it had also supported the .08 BAC standard for all drivers, as a step toward the .05 BAC standard adopted by the House of Delegates. SB 308 became 1991 Wisconsin Act 277.

ATV safety. SB 238, as introduced, prohibits all-terrain vehicle operation for children under 16, prohibits passengers, and requires helmet use for those under 18. The bill, as passed by both houses, was severely compromised; it retains the helmet requirement for minors, with exceptions if the ATV is used for traveling to and from hunting or fishing, or for agricultural purposes. Children under 12 are prohibited from ATV operation, except if on their own land or if used for agricultural purposes. The SMS supported the legislation, but preferred the original bill. The bill was enacted as 1991 Wisconsin Act 303.

Child seat restraints. SB 326 makes modifications to the child seat restraint requirement applicable in the motor vehicle transport of children. Under the bill, the driver and any adult in the car share responsibility for assuring that the child is properly restrained. Current law places the responsibility on the parent, if present, and if not, the driver is responsible. The bill also expands the age limits for required seat restraint use. Children under age 4 (now 2) must be in an approved seat restraint, and children under age 8 (now 4) must be secured by a seat restraint or seat belt. Finally, the bill repeals a provision in current law which states that no person is required to have more than three child safety restraint systems in a vehicle. The bill was enacted as 1991 Wisconsin Act 198.

Fireworks regulation. SB 429 and AB 772 would remove certain fireworks devices from state regulation. The bills also proposed to prohibit local governments from adopting ordinances which are more restrictive than state law. The SMS opposed the bills. Neither of them passed.

Farm safety. Senate Joint Resolution 62, which was adopted, requests a Legislative Council study on farm safety for purposes of recommending legislation to improve farm safety and to examine methods to educate farm families about farm safety. An interim study committee on farm safety issues will likely be appointed as a result.

Tanning booth regulation. AB 174 establishes regulations for the operation of tanning facilities through the DHSS. The bill addresses a variety of equipment standards, and requires written notices and warning signs primarily concerning dangers to the eyes and skin. The bill became 1991 Wisconsin Act 192. The SMS supported the bill.

Drinking age. As is the norm, bills to alter Wisconsin's drinking age law were again introduced. One bill (AB 219) proposed to lower Wisconsin's minimum drinking age from 21 to 19, and another bill (AB 911) proposed to lower the age to 19 for members of the US Armed Forces and for veterans. Neither bill passed. A related bill (AB 220) was considered which would authorize 18-, 19- and 20-year-olds to be on-premises in establishments authorized to sell alcoholic beverages, but the underage person would not be permitted to consume alcohol. That bill narrowly passed the Assembly, before dying in a Senate committee. The SMS supports retention of the current minimum drinking age of 21.

EMT defibrillation. Both houses approved legislation (AB 664), which formalizes an existing DHSS program establishing certification standards for EMTs, at the basic and intermediate level, to perform defibrillation. The SMS supported the bill. Prior to its approval, an authorization was added for the DHSS to establish certification standards for first responders to perform defibrillation with automated units. The bill was enacted as 1991 Wisconsin Act 238.

Motorcycle helmets. AB 917, which requires all motorcycle operators and passengers to wear protective headgear, was introduced in the Assembly. Current Wisconsin law requires only persons under

18 and persons holding motorcycle instructional permits to wear helmets. The bill died in an Assembly committee. The SMS supported the bill.

Tobacco

Smoke-free hospitals and clinics. The SMS and the Wisconsin Hospital Association jointly requested introduction of SB 130 to amend Wisconsin's Clean Indoor Air Act and direct all hospitals and physicians' offices to become smoke-free environments. The bill responds to a resolution adopted by the SMS House of Delegates. An amendment to the bill makes an exception for inpatient facilities or units within inpatient facilities that have as a primary purpose the care and treatment of mental illness or alcoholism and other drug abuse. Those facilities may designate one or more smoking areas for use by adult patients who have written permission of a physician. The bill became 1991 Wisconsin Act 130; it becomes effective Oct 1, 1993.

Cigarette vending machines. Four bills were introduced aimed at restricting minors' access to cigarettes from vending machines. Under the bill (SB 155) that passed, cigarette vending machines may not be kept in a place that is open to persons under age 18 unless placed in an area in the immediate vicinity, plain view and control of an employee. The vending machine must also be inaccessible to the public when the premises are closed. The bill also prohibits the possession of cigarettes or tobacco products by minors. The bill was enacted as 1991 Wisconsin Act 95; it became effective April 1, 1992. The SMS supported the bill.

Smokers' rights. SB 292 and AB 570 were introduced to prohibit employment discrimination based on an individual's use of a lawful product outside the workplace. SB 292 passed both houses and was approved by the governor as 1991 Wisconsin Act 310. The SMS opposed the legislation.

Clean Indoor Air Act. SB 480 would make several changes to Wisconsin's Clean Indoor Air Act: reducing from 50 to 30 the seating capacity threshold for restaurants that must comply with the law; extending application of the law to private schools and universities; and prohibiting smoking in juvenile correctional facilities. The bill also requires the DHSS or its agents to enforce the law as part of the restaurant inspection process. SB 480 died in Senate committee. It was supported by the SMS.

Free distribution of cigarettes. AB 51 would allow cities, villages or towns to enact ordinances to prohibit the promotional free distribution of cigarettes on a street, alley or other area used for pedestrian travel. The bill passed the Assembly but died in the Senate. The SMS supported the bill.

Cigarette tax increase. Various proposals were introduced to raise the cigarette tax and earmark all, or a portion, of the increased revenue for health-related programs. Ultimately, the cigarette tax was increased by 8 cents (to 38 cents) in SB 483, but the proceeds were not earmarked in any manner. Instead, the funds are treated as general purpose revenue. The tax increase was enacted in 1991 Wisconsin Act 269. The SMS supported increasing the cigarette tax and using the funds for health-related programs.

Tobacco Research and Intervention Program. AB 996 was introduced to provide funding to the University of Wisconsin Medical School for its Tobacco Research and Intervention Program (TRIP). The program's mission is the reduction of illness and death resulting from tobacco use in Wisconsin. TRIP's chief areas of focus are developing techniques to improve the frequency and effectiveness of physician interaction with smokers and to provide various research, education and treatment initiatives concerning smoking cessation for Wisconsin citizens. State funding is derived from a tax on retail cigarette licenses. TRIP would be required to accumulate matching funds from other sources before receiving state funds. Funding for the program was inserted in the biennial budget bill, but it was vetoed by the governor. AB 996 died in Assembly committee. The SMS supported the program.

AIDS and HIV infection

HIV/STD testing in sexual assault cases. AB 129 would create a mechanism for a sexual assault victim to obtain a court order for HIV and sexually transmitted disease testing of the alleged assailant. SB 483 was amended to include this provision. The governor approved this process in 1991 Wisconsin Act 269, but vetoed a requirement that the victim be likewise tested. The SMS supported the provision.

SB 483 HIV provisions. In addition to the above provision, the budget adjustment bill was amended to include a number of HIV-related provisions. As subsequently modified through line-item vetoes, the newly enacted provisions are as follows:

- enable EMTs, firefighters and peace and correctional officers, who provide care or services to a person in the line of duty and who are significantly exposed, to request a court order for HIV testing of the person;
- expand the list of persons who are prohibited from discriminating against persons with HIV to include firefighters and peace and correctional officers;
- increase from 18 to 29 months the maximum period the DHSS is required to cover persons with HIV under the insurance continuation premium subsidy program;
- create a health insurance premium subsidy program for people who are on medical leave from their jobs (the current subsidy program covers only these who have quit their jobs or reduced their hours worked);
- include home health agencies under the definition of health care provider within the laws covering HIV testing without consent;
- create a more specific definition of "significantly exposed" by including references to vaginal secretions, cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids and deleting references to exposure to saliva as a result of a bite and to the provision of CPR; and
- modify requirements for testing per-

sons who donate human sperm and ova for the presence of HIV.

Occupational puncture injuries. AB 414, which passed both houses, provides a grant program within the DHSS for providing two to five grants for projects to test the practicality and effectiveness of using devices that are designed to prevent occupational puncture injuries. The grants would be provided to hospitals and nursing homes with significant numbers of HIV-infected patients. In a partial veto, the governor reduced the appropriation, eliminated specification of the number of grants, removed nursing homes' ability to apply for the grants and removed the limitation that the grants be directed only to facilities with a high incidence of HIV infected patients. The remainder of the bill became 1991 Wisconsin Act 290.

HIV education. AB 893 would have required schools to provide instructional programs designed to give pupils in grades 6 to 12 knowledge of HIV infection and AIDS. The bill was favorably recommended by Assembly committee, but died in the Joint Finance Committee. The SMS supported the bill.

Health professions

Physical therapy assistant supervision. SB 81 changed the supervision standard for physical therapy assistants by physical therapists. The change authorizes general supervision, as defined by MEB rule, rather than direct, immediate, on-premises supervision as required by previous law. SB 81 became 1991 Wisconsin Act 23. The SMS supported the bill.

Social worker regulation. AB 125 provides for the licensure of social workers, marriage and family therapists, and professional counselors. The original bill also mandated health insurance coverage for services provided by independent clinical social workers, marriage and family therapists, and professional counselors. The SMS opposed the legislation, particularly the insurance mandate. The insurance mandate was removed and the remainder of the bill, with some modifications, was passed and signed into law in 1991 Wisconsin Act 160.

Pharmacy practice. AB 267 was requested by the Pharmacy Examining Board to modify laws governing the practice of pharmacy. The provisions were minor in nature, except for one provision to expand pharmacy scope of practice to include "monitoring the therapeutic appropriateness of a prescribed drug on a patient" as a statutory responsibility. The SMS felt the language invited a range of interpretations concerning pharmacists' patient responsibilities and worked to modify the bill. An agreement was reached with representatives of the Pharmacy Examining Board to substitute the following language for the above so that pharmacists' responsibilities include "drug regimen screening, including screening for therapeutic duplication, drug-to-drug interactions, incorrect dosage, incorrect duration of treatment, drug allergy reactions, and clinical abuse or misuse." AB 267 was enacted with the compromise language and became 1991 Wisconsin Act 114.

Psychologist hospital privileges. AB 432 dealt with hospital staff privileges for psychologists. Initial drafts of the bill mandated that hospitals grant privileges to psychologists. Other provisions would have barred hospitals from granting only limited or selected privileges. The SMS succeeded in eliminating the mandate for granting privileges and in preserving existing standards, as set forth by hospital regulations and accrediting bodies, for the determination of hospital privileges and the scope of those privileges. AB 432, as modified, was enacted as 1991 Wisconsin Act 129.

Physician assistants. AB 443 adds physician assistants to the definition of health care provider under the statutes. Because the definition is cross-referenced with several other statutes it recognizes PAs in laws dealing with medical records access, witness provisions regarding living wills and durable power of attorney for health care, and other laws. The SMS supported the bill, but it died in an Assembly committee.

Nurse-midwife programs. AB 615, developed by the Legislative Council's Special Committee on Prenatal Care, would have required hospitals to grant staff privileges to nurse-midwives if the supervising or collaborating physician has staff privileges at the same hospital. It would also require health insurance policies to cover nurse-midwifery services if the same services are covered when provided by another health care provider, and would establish a loan repayment program for nurse-midwives who practice in medical shortage areas. Unsuccessful attempts were made to attach this bill, and variations thereto, as an amendment to SB 483. AB 615 did not receive action by the Assembly.

Miscellaneous

Unauthorized release of animals. AB 33 created penalties ranging from civil damages to criminal charges against persons who intentionally release lawfully confined animals without the owner's or custodian's consent. Animals confined for scientific, research, farming, commercial, educational or other purposes are covered by the bill. The bill became 1991 Wisconsin Act 20. The SMS supported the bill.

Living wills. SB 282 and AB 559 were introduced to authorize persons, as part of a living will, the option of prospectively consenting to or refusing the use of medical feeding tubes in the event of a terminal condition, and to the use of medical feeding tubes or life-sustaining procedures in the event of a persistent vegetative state. AB 559 was enacted. Previous living will law did not allow for prospective consent to withhold or withdraw nutrition or hydration, nor did previous law allow living wills to be effective for persistent vegetative states. The bill also provides that a person's durable power of attorney for health care supersedes any conflicting portions of the person's living will. The bill became 1991 Wisconsin Act 84. The SMS supported the bill.

Worker's Compensation. The Worker's

Compensation Advisory Council's bill (AB 571) resolved the major differences the SMS had with the council's bill from the previous session. Previous law allowed parties involved in a Worker's Compensation case to dispute the reasonableness of health care provider fees or the necessity of treatment and then allowed an administrative law judge to make a ruling on the dispute, without defined standards for making such determinations. AB 571 establishes a formula system derived from certified data bases for making determinations in fee disputes. The bill also prescribes a process, including obtaining opinions from qualified experts, for resolving necessity of treatment disputes. In addition, the bill provides increased fees for providing medical records for Worker's Compensation cases so that the greater of $7.50 (now $5) per request, or 45 cents (now 25 cents) per page, plus postage costs may be charged to requestors. Copying charges for records requested in other civil actions will be subject to limits set by administrative rule; see the Health Regulation section. The bill was enacted and became 1991 Wisconsin Act 85.

School drug administration policies. Under current law, school employees or volunteers may be authorized by school administrators to administer medications to pupils. School boards must adopt a written policy governing the administration of the medication. AB 290 was enacted to require schools, when developing their drug administration policies, to seek the assistance of school nurses or nurses or physicians in the community. The bill became 1991 Wisconsin Act 103. The SMS supported the bill.

Genetic testing. AB 515 was enacted to prohibit employers, employment agencies, labor organizations or licensing agencies from requiring genetic testing of any person as a condition of employment, membership or licensure. The bill, which was supported by the SMS, became 1991 Wisconsin Act 117.

EMS medical director. AB 914 was introduced to create a position of state medical director of emergency medical services and require the position to be filled by a physician with training and experience in emergency medicine. The bill also establishes an EMS medical advisory committee to assist the medical director in developing standards, policies and procedures for the EMS system. The bill was unanimously recommended for passage in Assembly committee before it died in the Joint Finance Committee. The SMS supported the bill pursuant to policy adopted by the House of Delegates.

Parental consent for minor's abortion. AB 180 prohibits physicians from performing abortions on minors who are not emancipated without first obtaining proper consent. Written consent from the minor, as well as written consent from a parent, legal guardian, or an adult family member must be received prior to the abortion. In lieu of obtaining the above consent, the minor, or a member of the clergy on the minor's behalf, may petition circuit court to approve the abortion and the abortion may be performed upon receipt of the approved documentation.

Various exceptions to the above apply. The abortion may be performed without adult or court approval if a medical emergency complicates the pregnancy or if a psychiatrist or psychologist states in writing that the minor is likely to commit suicide rather than seek the required consent or court approval. Further, the abortion may be performed if the minor states to the physician in writing that she is a victim of child abuse, or that the pregnancy resulted from sexual assault, incest, or from an adult male residing in the household. The physician must report the violations from the written statement to proper authorities. For purposes of this law, an adult family member is considered to be a grandparent, aunt, uncle, sister or brother at least 25 years old.

An emancipated minor is considered to be a minor who is or has been married; a minor who has previously given birth; or a minor who has been freed from care, custody and control of her parents with little likelihood of returning prior to marriage or prior to the age of majority. Only physicians may perform a minor's abortion under the legislation. Any person who performs an abortion in violation of the above requirements is subject to a fine of up to $10,000 and civil damages. AB 180 became 1991 Wisconsin Act 263.

150 YEARS OF CARING
THE STATE MEDICAL SOCIETY OF WISCONSIN

A remarkable woman: Margaret Trevitt, MD, 1858-1925

Cheri Volkert, RN, Wausau

MAY 4, 1886: A HORSE-DRAWN CARRIAGE bounced over Wausau's muddy streets, joggling its two young passengers. The couple were strangers to this bustling Wisconsin city and, eager to begin their lives anew, gazed curiously at their surroundings.

In the distance, they heard the afternoon train whistle screech above the incessant buzzing from saw mills, and listened to the resounding booms of pine logs floating down the Wisconsin River.

The contemplative dark-haired woman noted the vast array of flowers adorning the grand homes, and sniffed the air to catch their aroma.

The May 8, 1886, *Central Wisconsin Newspaper* read, "Drs A. W. Trevitt and M. T. Trevitt arrived in Wausau on Tuesday. Their furniture for the hospital has arrived and the building is being fitted up for patients. The physicians are highly recommended by the Stevens Point papers as being skilled in their profession. Mrs Dr Trevitt is especially spoken of as being a highly educated, practical, and successful physician. That they may acquire a good practice in this city and have the same success here that has been their lot elsewhere, is the wish of all."

Dr M. T. Trevitt was born Margaret Trout Johnson Sept 1, 1858, in Barrie, Ontario, Canada, located on the western shore of Lake Semicoe. This daughter of Scottish immigrants was to become one of Wisconsin's first practicing female physicians.

Margaret received her primary education in Barrie, later attended the Massey School in Toronto, and then earned her medical degree from the Electic Medical College in Cincinnati.

On Nov 20, 1883, the 25-year-old Margaret married Dr Alfred W. Trevitt. The following spring, the two doctors moved to Stevens Point, where Alfred became manager of the local hospital, having had a "one-fourth interest" in it.

Margaret Trevitt, MD

This hospital was a branch of the American Hospital Aid Association, which also had branches at Minneapolis, Bay City and Reed City, Mich, and Eau Claire. These institutions, called ticket hospitals, offered a unique health care program.

Every autumn, agents visited lumber camps in northern Michigan and Wisconsin and sold $10 tickets to lumberjacks that entitled them to all medical and surgical care for 1 year, no matter which ticket hospital they entered. Turkish,

Continued on next page

Volkert is a member of the Marathon County Auxilary. Reprint requests to: Cheri Volkert, RN, 3334 N 13th St, Wausau, WI 54401.
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Continued from preceding page
Russian, electric, and all kinds of medicated baths were also included. If the policy holder did not need medical care, the hospital kept the $10. The contract also agreed to pay $5 per week for total disability.

In May 1886, the *Stevens Point Journal* read, "The Doctors Trevitt desired to get nearer the upper lumber camps and also where they can reach the iron mining district...."

It was in the midst of this attitude, and when curling clubs, tennis, and competitive football, baseball, and basketball teams were sprouting in Wausau, that the Trevitts opened their 25-bed hospital in a two-story building. Margaret specialized in treating "diseases of women and children."

"While in Stevens Point, over the past four years, more than 1000 patients were treated. Although they had a large number of patients there this winter only one death occurred, which speaks well for Dr (Alfred) Trevitt's ability as a physician and surgeon. Besides being an able physician, he is a pleasant gentleman and a valuable addition to our city ... the institution will prove a blessing in many ways," stated the May 18, 1886, *Wausau River Pilot.*

After 3 years, however, this ticket branch closed due to the low number of patients and financial difficulties.

For a brief time during 1891, the Trevitts, along with another young physician, Dr Douglas Sauerhering, used a small frame house for their second hospital. Soon that closed, too, so the Trevitts opened a private office.

Margaret and her husband continued their practices while immersing themselves in community affairs.

Alfred was a staunch Republican who served as a stump speaker for the party. In 1908, during the "heat of the presidential race," the Trevitts entertained William Howard Taft at their home in Wausau.

Margaret became an active member in the Universalist Church as a First Matron of the Eastern Star and a Sunday school instructor.

She also joined the Ladies Literary Club of Wausau, which in 1935 became the Wausau Women's Club. According to the club's constitution, the purpose was "the promotion of the intellectual and social culture in the community and the advancement of whatever relates to the best interest of the city."

From April 1900 to April 1902, and from April 1915 to April 1916, Margaret was president of the Literary Society, which had 70 members, chaired the Philanthropy and Reform Committee, gave a talk titled "The Trailing Skirt As A Microbe Gatherer," and assisted in the research of 10 papers that were voted to the "Archives of the Reciprocity Bureau."

During the next 22 years, this society increased its interest in civic affairs. Members planted 500 trees, cleaned up and beautified areas on the riverbank, provided ornamental gates for the Pine Grove Cemetery, obtained murals and paintings for school walls, and helped establish the Wausau library and Mt View Sanatorium.

In the fall of 1903, Margaret and Alfred became charter members of the Marathon County Medical Society.

While the Trevitts opened their private office in 1892, Dr Sauerhering opened the third Wausau hospital called the River Side Hospital. But in 1901, Dr Sauerhering resigned as medical superintendent, stunning the physicians on staff, including the Trevitts. River Side Hospital was in financial trouble and the building was in decrepit condition. The Evangelical-Lutheran Hospital Association continued to operate the hospital, relying greatly on ticket sales for its expense, but by 1905, it was clear that Riverside Hospital needed outside help–and Margaret was to play a role.

Rev James Brennan, pastor of St James parish in Wausau, wrote to the Sisters of Divine Savior in Milwaukee relaying Dr Sauerhering's request that the Catholic nuns visit Wausau and take over the hospital. After many prayers and a few complications, the nuns agreed and sent three from their order to Wausau in December 1905. Although Riverside was in wretched condition, the nuns took immediate responsibility and admitted their first patient–a poor man who was unable to pay for his care.

A note in their records states, "God is surely blessing us in sending the poor as our first patient." By the end of January 1906 the nuns had 19 patients and changed the hospital's name to St Mary's. Patients were attracted by the nuns' simplicity and concern, and were charged $1 per day. If they could not afford the cost, local women came to their rescue.

After consulting with the nuns, Margaret organized and became president of the Free Bed Committee, which raised money to provide medical and surgical care for indigent patients. It also arranged transactions so that the poor patients' identities were never revealed.

Margaret also organized the first Annual Charity Ball, which led to the Ladies Auxiliary of St Mary's organization.

Physicians of the time were kept busy and endured many inconveniences. Diphtheria, smallpox, scarlet fever, typhoid fever, and other contagious diseases were common. In summer months there was a high percentage of intestinal diseases which resulted in more deaths–especially among children.

Margaret's fellow physician, Dr S. M. B. Smith recalled, "It is probably difficult for ... you to realize just what is meant by the term of horse-and-buggy doctors, and what it meant to have to get up during cold and stormy nights, hitch up a tired horse and drive out on a call without heat or light, in a buggy or an open cutter, with prices ranging from two to three dollars for that same call."

Margaret and her fellow physicians used carbolic acid and chloride of mercury to sterilize equipment. Patients were vaccinated for smallpox by rubbing celluloid covered with vaccine over a scratched area on the arm, which caused many infections.

Despite the support from the citizens and medical community of Wausau, St Mary's Hospital was beyond repair by

1906. The nuns wrote to Rome, requesting and gaining permission to build a new facility. The new hospital was dedicated in September 1908. Judge Louis Marchetti eulogized the new hospital: "Although St Mary's was operated by a Catholic sisterhood denomination, it was non-sectarian in its service.... There is no distinction in race, color, or creed, all being equally welcome and well cared for.... Every physician and surgeon in good standing has access to the hospital and may treat patients there.... To be helpful is their only ambition. Its reputation and that of the attending physicians has spread far beyond Marathon County...."

But the next few years were not without hardships. St Mary's was a mile beyond the streetcar limits on roads that were filled with mud and sinkholes in the spring, dusty in summer and fall, and covered with snow in winter. Frequently, patients and doctors could not get to the hospital until the nuns shoveled a path through the immense snow drifts.

In 1918, a Spanish influenza epidemic occurred throughout the United States, hitting Wausau in October. By the end of that month 42 people had died; another 29 perished in November.

All businesses, including churches, were ordered closed, except for grocery stores. Patients were quarantined, and medical placard notices were placed on front doors, but many citizens ignored the warning and the disease spread. Schools were closed and filled with cots, as were public halls. Doctors worked day and night, often without meals, caring for the sick.

During those years, Margaret–in addition to raising her daughter and maintaining her medical practice–was vigorously involved with welfare and charitable work. She was also a charter member of the Federated Charities. A year after the Spanish influenza epidemic, the citizens of Wausau had pretty much recovered and the Trevitts resumed their normal activities–until tragedy struck.

In 1922, Margaret suffered a paralytic stroke. Her husband thought she would recover "as she was able to be about and, among other things, take long automobile rides." But during the summer of 1925 she required constant care. After several "spells of indisposition" she was confined to bed.

On the morning of Dec 7, 1925, Dr Margaret Trout Johnson Trevitt died.

Her funeral was in the family parlor and was attended by many friends and relatives, including her fellow physicians.

The Dec 10, 1925, issue of the *Wausau River Pilot* recounted:

"Dr Margaret held a high place in the hearts of our people.... It was characteristic of her life to "feed the hungry, clothe the naked, and bind up the wounds of the afflicted. And all of this she did without ostentation and without the least hope of reward.

"She was interested in every movement that helped better conditions in Wausau and Marathon County, never hesitating to express her ideas of right and wrong and always using her influence to advance the former.

"Her death is mourned by a large circle of friends and the community in general feels that a noble life has been taken from us."[15,0H]

A glimpse into our past

Richard D. Sautter, MD, medical editor

37 years ago

In defense of medicine. William S. Middleton, MD, addressed public attitudes toward physicians. "Obviously, the traditional patient-physician relationship has undergone a serious deterioration within recent years; but the movement is not new. Superficial observers have found medicine as easy prey through the ages. Voltaire wrote, 'A physician is one who pours drugs of which he knows little into a body of which he knows less.' ...(Today) medicine is clearly on the defensive. We have been openly charged with reducing the output of our medical schools in interest of a monopoly of services. The decision of a high court of the land has found medicine to be a trade ... Federalization of medicine has become a national issue." Apparently, Dr Middleton was as good a prognosticator as he was physician and teacher.

Rural physicians v chiropractors. "Through the years," Dr Middleton wrote, continuing his analysis of the patient-physician relationship, "my duties have taken me into the prosperous agricultural district of Wisconsin. From time to time an older physician has retired or died in one of the small towns along this highway. In each instance his place has been taken by an irregular practitioner; ie, osteopath or chiropractor. In one of our neighboring states half the country practice is in the hands of osteopaths. Heed well the signs at the crossroads. The affection of the people lies close to the hearthstones of their homes." While tolerance for "irregular practitioners" has grown, and osteopathic physicians have become colleagues , the closing axiom is sound.

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The search for Reds. The AMA warned federation members, "As a safeguard against any suspicions of communist sympathies, physicians who wish to keep their record straight should write to the National Council of American-Soviet Friendship, requesting their names be taken off that organization's mailing list." Physicians were directed to send a carbon copy of the letter to the FBI. Apparently, some things *do* change.

67 years ago

Casting off the bonds of big brother. The SMS House of Delegates passed a resolution expressing disapproval of portions of "the National Prohibition Acts which interfere with the proper relation between the physician and his patient in prescribing alcohol medicinally." I'd like to know the exact circumstances in which alcohol was considered medicinal.

"It is just as fair for the government to limit the amount of aspirin you can prescribe or the amount of nux vomica as to limit the amount of whiskey. It is a practice against governmental regulation of medicinal practice," then-SMS president Rock Sleyster, MD, stated. The government's been at it a long time.

Makes you wonder how they interpreted the Biblical passage: "Drink no longer water, but use a little wine for thy stomach's sake." (I Timothy 5:23).

A change in focus. Dr Hoyt Dearholt wrote an editorial in the *WMJ* noting an historic change in medicine's approach to public health: "We have come to the era ... in which *people*, not *things,* will need to be controlled. Instead of the *community* being the sanitary unit, the *family* will become such. And just as epidemiologists have inspected lakes and streams, streets and alleys, houses and rooms, for sources of disease spread and means of control, so will private physicians increasingly search lungs, tonsils, teeth, hearts and kidneys for signs of disease outbreaks...

97 years ago

A change in membership. The medical society approved an amendment to the constitution allowing for the first time physicians to join the society without having to physically attend meetings. The matter was not resolved without dissent. "It seems to me that if anyone is interested enough to desire membership in the society, he ought to come in person," one physician said. But others noted the advantages of such a policy change, and the secretary predicted the membership would be largely increased with adoption of the provision.

The yuppies didn't invent it. Chronic fatigue syndrome, the condition that is unkindly called by some the "yuppie disease," was, in 1895, called neurasthenia: "an exhausted condition of the nervous system ... most prevalent among brain workers (and) of frequent occurrence among physicians." The treatments of the time, administered at sanitariums, were "rest, good food, tonics, electricity and baths." There's a novel idea: eating right, getting enough rest and taking some time off is good for what ails you. It's probably a good prescription for non-brain workers, too.

Physician briefs

Mark H. Attermeier, MD,* recently joined the family practice department at Midelfort Clinic in Eau Claire. Dr Attermeier earned his medical degree from the University of Wisconsin School of Medicine and completed his residency in the UW-sponsored Eau Claire Family Practice Program. He has been a member of the family practice staff at Group Health Cooperative in Eau Claire since 1980. He served as medical chief of staff at Sacred Heart Hospital in Eau Claire from 1986 to 1988.

Kathryn W. Brimhall, MD,* a Sheboygan psychiatrist, has accepted the position of co-medical director for the Center for Chemical Dependency and Mental Health Services there. A 1987 graduate of St Louis University School of Medicine, Dr Brimhall performed a 1-year internship in obstetrics and gynecology at St Joseph's Hospital in Milwaukee. She recently completed her residency in psychiatry at the Medical College of Wisconsin and continues to serve on the college's clinical faculty.

Kevin Fullin, MD,* a Kenosha cardiologist known for his strong stand against family violence, has been selected to receive the Wisconsin Victim/Witness Professionals 1992 Award for Outstanding Victim Advocacy. Dr Fullin shares the award with **Wanda Bincer, MD,*** a Madison psychiatrist who founded the Wisconsin chapter of Parents of Murdered Children after her daughter was murdered in Atlanta, Ga.

W. Bruce Fye, MD,* of Marshfield, has been appointed by the American College of Cardiology's Board of Trustees to a 6-year term as college historian. Dr Fye chairs both the ACC's Library Committee and the Marshfield Clinic's Cardiology Department. He is an adjunct professor of the history of medicine at the University of Wisconsin and holds a master of arts degree in medical history from the Johns

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Hopkins Institute of the History of Medicine.

Paul R. Holzman, MD, has joined **Dr William Faller** in providing pathology services for Door County Memorial Hospital. Dr Holzman is certified by the American Board of Pathology and the National Board of Medical Examiners. Dr Holzman most recently served in the US Air Force on staff in the department of gynecology and breast pathology at the Armed Forces Institute of Pathology in Washington, DC. He was also staff pathologist at the Macolm Grow USAF Medical Center at Andrews Air Force Base in Maryland. He is a graduate of the University of Wisconsin School of Medicine.

Robert Madden, MD,* and Joseph Wepfer, MD,* are the recipients of the 1992 Golden Trumpet Award, presented by the Centurians organization of St Joseph's Hospital, of Milwaukee. The annual award is presented to those who have made a significant contribution to the health care industry. Dr Madden has been associated with the hospital since 1957 and Dr Wepfer has been a member of the hospital's medical staff since 1951.

William Marx, MD, has established a clinic half way between Webster and Spooner. A family practice physician, Dr Marx recently relocated with his family from Sitka, Alaska.

Peter Melcher, MD,* has been named Howard Young Medical Center's "Physician of the Year-1992." Dr Melcher, an orthopedic specialist, is a 12-year member of the HYMC medical staff. A native of Pennsylvania, Dr Melcher earned his medical degree from the New Jersey College of Medicine at Newark. He served his residency at the University of Washington in Seattle with 2 years of surgery and 5 years of orthopedics.

David Murdock, MD, staff cardiologist at the Wausau Hospital Center, has been selected to receive an Alumni Association Achievement Award from Illinois State University. Three awards were given. Dr Murdock earned his medical degree from Stritch School of Medicine at Loyola University in Chicago. His career has involved extensive research in coronary heart disease. He is nationally recognized for his work in cardiac catheterization.

Robert Penn, MD, an internist, has joined the Janesville Medical Center. Relocating from Illinois, Dr Penn earned his medical degree from Indiana University.

Denise Pettitt, MD, is a new addition to the Waukesha Memorial Hospital staff. A child, adolescent and adult psychiatrist, Dr Pettitt's professional interests include childhood Tourette's Syndrome and obsessive compulsive disorders.

County society news

Dodge. Craig Griebel, MD, of Beaver Dam, has been accepted into the Dodge County Medical Society.

Fond du Lac. At the April meeting of the society, John B. Butler, MD, and Joan T. Sumkin, MD, both of Fond du Lac, were accepted to membership. The guest speaker for the meeting was Jim Putnam, of Appleton, who spoke on financial and retirement investment strategies.

Marathon. William Arthur Bowler, MD, and Glen J. Heinzl, MD, have been accpeted into membership of the society.

Milwaukee. New members of the Medical Society of Milwaukee County are: Arthur A. Arena, MD; Carol D. Barber, MD; Pedro Cano, MD; Thomas B. Corsolini, MD; Emanuel Fantone, MD; Divyakant B. Gandhi, MD; Scott E. Hagadorn, MD; Sandra A. Herbage, MD; Steven J. Heyden, MD; Keith A. Kirby, MD; Franklin Loo, MD; Francisco M. Mabini, Jr, MD; Evelina Mendoza-Mabini, MD; Nabil M. Metwally, MD; John E. Midtling, MD; Robert M. Molly, MD; Gregory G. Pacentine, DO; Susan L. Pfleger, MD; Edward J. Plecha, MD; Carol C. Pohl, MD; Frederico A. Sanchez, MD; Czeslaw Szymanski, MD; Jessica L. Thomasons, MD; Robert J. Witte, MD; Gretchen M. Zirbel, MD; and candidates Jeanne Schmitz and Lara Eisenberg.

Outagamie. Twenty members and guests were at the April meeting of the Outagamie County Medical Society to hear Montgomery J. Elmer, MD, and Robert S. Fox, MD, from the Physicians Concerned for Social Responsibility. Their subject was the medical relief efforts for Appleton's sister city, Kurgon, Russia. New members accepted into membership of the society are Stephen R. Peter, MD, Michael J. Reinardy, MD, and Stephen M. Damiani, DO.

Vernon. Cyril M. "Kim" Hetsko, MD, immediate past president of SMS, was the featured speaker at the April meeting of the society. Current trends and legislative developments of concern to organized medicine were the focus of his talk.

Winnebago. Kenneth Viste, MD, past president of SMS, was the featured speaker at the Winnebago County Medical Society meeting. Twenty-two members and guests were present to hear him speak on the national political environment, with its future manipulation of the medical system.

Obituaries

Edwin H. Jorris, MD, 86, Sarasota, Fla, formerly of Madison, died April 1, 1992, in Sarasota. Dr Jorris was born June 21, 1905, in La Crosse, and graduated from the University of Minnesota School of Medicine. His internship was served at St Mary's Hospital in Duluth, Minn. Dr Jorris practiced family medicine in Excelsior for 5 years, and then did graduate study at the University of Michigan, from which he received a master of science degree in public health administration. He served in the US Navy for 3 years. After his military service, Dr Jorris returned to his position with the Wisconsin Board of Health and, in 1965, was appointed state health officer. Dr Jorris retired in 1972. He was a fellow of the American Board of Preventive Medicine and a member of the American Public Health Association. He also was a member of the Dane County Medical Society, the SMS, and the AMA. Surviving are two children, Patrick, of Monona, and Gail Kleinheinz, of Buford, Ga.

Marcus K. Mookerjee, MD, 85, of Milwaukee, died March 31, 1992, in Milwaukee. Dr Mookerjee was born Nov 14, 1906, in Calcutta, and graduated from the University of Minnesota Medical School. His internship was completed at the Charles T. Miller Hospital, St Paul, Minn, and his residency at Cook County Hospital in Chicago. Dr Mookerjee served in the US Army from 1942 to 1946. He was a member of the SMS 50 Year Club and served on the medical staffs of Columbia, Deaconess, and St Anthony hospitals. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Myrlene; daughters, Barbara Ross and Mary Vincent; and stepchildren Connie McCartney and Gary Kyle.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.[150th]

Lionel T. Servis, MD, 78, a Milwaukee physician, died Feb 25, 1992, in Sarasota, Fla. Dr Servis was born Oct 25, 1913, in Chicago. He graduated from Marquette University School of Medicine and served his internship and residency at Milwaukee County General Hospital. He was on the medical staff of Milwaukee County Medical Complex in Wauwatosa, St Joseph's, and Columbia hospitals in Milwaukee. He had a private medical practice from 1944 until his retirement in 1982, and also was an assistant professor of medicine at the Marquette School of Medicine. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Elizabeth, of Milwaukee, and Venice, Fla; a son, Jeffrey, of Milwaukee; and two daughters, Minna, of Gig Harbor, Wash, and Victoria Lawrence, of Alamo, Calif.

Stephen L. Weld, MD, 75, of Two Rivers, and Stuart, Fla, died April 4, 1992, in Stuart. Dr Weld was born June 25, 1916, in Campbellsport, and graduated from Temple University Medical School in Philadelphia. His internship was served at St Joseph's Hospital in Milwaukee, and his residency completed at St Mary's Hospital in Racine, and Henry Ford Hospital in Detroit. Dr Weld had practiced in Two Rivers since 1943 and retired in 1981. He was a member of Manitowoc County Medical Society, the SMS, and the AMA. Surviving are his widow, Carole; a son, Stephen, of Eau Claire; two daughters, Kaye Michaels, of Milwaukee; and Laurie Gommerman, of Wautoma; and 10 grandchildren.[150th]

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All manuscripts will be edited by the *Journal* staff for clarity, organization, grammar, spelling, and punctuation, and in accordance with AMA style (AMA *Manual of Style*, 8th ed, and AMA *Manual for Authors and Editors*). Suggestions for titles are welcome, but are subject to the constraints of clarity, space, grammar and style.

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- Submit papers to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701; Ph: 608-257-6781 or 1-800-362-9080; FAX: 608-283-5401.
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Abstracts–150 words or less, stating the problem considered, methods, results and conclusions. Cite no references.

Methods–Describe the selection of observational or experimental subjects, including controls. Identify the methods, procedures and equipment well enough to allow replication.

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- Avoid the use of medical jargon. Words or phrases that are particular to conversations among medical personnel are inappropriate in scientific writing. (Examples: For "presented with" use "had;" for "experienced a weight loss" use "lost weight.")
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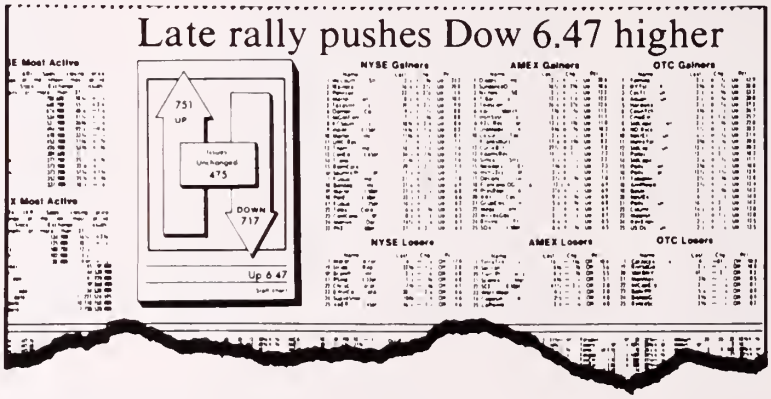

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Milwaukee area. A rapidly expanding 60 physician multi-specialty clinic, seeks BC/BE physicians in the following special specialties: **family practice, internal medicine, ob/gyn, urology, psychiatry and oncology.** Competitive salary, excellent fringe benefits. Address inquiries and CV to : Administrator, PO Box 427, Menomonee Falls, WI 53052-0427. 6-8/92

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Established Fox River Valley group seeking fourth BC/BE internist. Opportunity offers high earning potential with competitive benefits package, 5-way call and recently constructed modern offices adjacent to hospital. Many recreational and cultural amenities, excellent schools and universities, low crime rate, progressive and growing economy. Contact Bob Matuszak, Fox Hill Associates, 250 Regency Court, Waukesha, WI 53186; ph 800-338-7107. 5-6/92

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Board certified general surgeon. ACLS,ATLS seeks emergency room or urgent care position in SE Wisconsin area. Available July 1992. Please respond to Dept 634 in care of the Journal. 5-6/92

Staff psychiatrist. Medium-size smoke-free environment medical center offers primary and extended care to a large area of west central Wisconsin. Full range of psychiatric services include admissions (acute), geriatric, long-term care, out-patient, PTSD, and alcohol. Salary range to $119,500, depending on qualifications and board certification. Excellent benefits package includes malpractice protection, 30 days paid vacation, and annuity plan. Relocation expenses. 173-acre facility includes limited on-station housing and nine hole golf course. City of 7500 in a predominantly rural area that offers affordable real estate, good schools. conveniently located on I-90/94

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midway between Milwaukee and Minneapolis. Call or write: Eugene J. Traynor, MD, Chief, Psychiatry Services (116A), VA Medical Center, 500 East Veterans St, Tomah, WI 54660; ph 1-800-252-7188. EO/AAE. 5-12/92

Emergency medicine-Wisconsin. Emergency department medical director and staff positions are available at several client hospitals in Wisconsin–Portage, Watertown, and Superior. All newer emergency departments with a wide range of specialties represented. Progressive hospitals with excellent nursing staff support. Annual ED volumes range from 8,000 to 10,000. Metropolitan areas only 45 minutes from all facilities. Fee-for-service contracts, reimbursement for Wisconsin Compensation Fund. Medical directors also offered full benefit package, administrative stipend, and participation in retirement plan after 12 months of service. For complete details on available opportunities in Wisconsin, contact Mallarry Dierkes, Spectrum Emergency Care, PO Box 419052, St Louis, MO 63141; 1-800-325-3982, ext 1029. 5-7/92

Oshkosh, Wisconsin. Single specialty groups are recruiting in orthopedic surgery, ophthalmology, child psychiatry, OB/GYN, and cardiology. Oshkosh is an attractive community of 55,000 (service area of 85,000) people located on the shores of Lake Winnebago and in the heart of Wisconsin's beautiful Fox River Valley. Competitive financial packages. Contact Christopher Kashnig, physician recruiter, Mercy Medical Center, 631 Hazel Street, Oshkosh, WI 54902; or call 800-242-5650 x2430 or 414-236-2430. 4-6/92

Family practice physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD,MBA, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 4-6/92

Urgent care. FT or PT opportunities available in busy, well established Cedar Rapids urgent care center. Occupational medicine including pre-employment evaluations and work-related injury treatment also are part of the practice. X-ray, laboratory, and physical therapy services available within clinic. Cedar Rapids, population 110,000 is located in eastern Iowa and is 30 minutes from the University of Iowa. Excellent compensation and scheduled hours. Mail CV or call Bob Waste, Mercy Care Management, PO Box 786, Cedar Rapids, Iowa 52406; ph 319-398-6460. 4-6/92

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The Wausau Medical Center is seeking board certified/eligible individuals in the following specialties: dermatology, family medicine, gastroenterology, hematology/oncology, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed

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Internist to join two internists in active practice in scenic Upper Michigan. Medical school affiliation. Contact North Shore Internal Medicine, 2420 First Ave South, Escanaba, MI 49829; ph 906-786-1563. p11tfn/91

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 55 cents per word, with a minimum charge of $25.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg*, copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association*.

Internist to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, new clinic and constructing new hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. c9tfn/91

Milwaukee suburb. New and rapidly expanding multi-specialty full-service clinic. Attractive benefits, salary, and early partnership opportunity. Positions available in internal medicine, family practice, and pediatrics. Please send CV to Administrator, Park Crest Medical Clinic, SC, 2665 South Moorland Rd, New Berlin, WI 53151. 3tfn/91

Wisconsin. 120 physician multi-specialty clinic in the Fox River Valley of northeastern Wisconsin desires two BC/BE pediatricians to join department of 15 BC/BE pediatricians. Excellent compensation and benefit package, leading to shareholder status after two years. The community offers a superb recreational, cultural, and family environment in which to practice. For information please call or write: Howard Kidd, MD, La Salle Clinic, 411 Lincoln St, Neenah, WI 54956; ph 414-727-4276. 3tfn/91

State Medical Society of Wisconsin

Dates and locations of
ANNUAL MEETINGS
1993-1994

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1993 - April 15-17: La Crosse Convention Center, Radisson
1994 - April 14-16: Milwaukee

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

Medical Meetings-Continuing Medical Education

August 5-9, 1992: 43rd Annual Meeting International Doctors in AA (IDAA) in Grant Rapids, Michigan. Registration information: Connie Hyde, 3311 Brookhill Circle, Lexington, KY 40502; ph 606-233-0000; 606-277-9379; 606-253-0864 (FAX). g3-7/92

September 25-26, 1992: *Issues in Primary Care*, at Landmark Inn and Resort, Egg Harbor, Wis. Info: Nadine Punke,Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449; ph 1-800-782-8581, ext 5207. 6-8/92

October 15-18, 1992: 44th Annual AAFP Scientific Assembly in San Diego. Info: AAFP, 8880 Ward Pkwy, Kansas City, MO 64114; ph 816-333-9700; 816-822-0580 (FAX). g3-9/92

November 8-12, 1992: Ninety-Sixth Annual Meeting of the American Academy of Ophthalmology at Dallas Center. Contact: The American Academy of Ophthalmology, Meetings Dept, PO Box 7424, San Francisco, CA 94120-7424; ph 415-561-8500. g3-9/92

AMA

December 6-9, 1992: Interim House of Delegates, Nashville.
June 13-17, 1993: Annual AMA House of Delegates, Chicago.
December 5-8, 1993: Interim House of Delegates, New Orleans.
June 12-16, 1994: Annual AMA House of Delegates, Chicago.
December 4-7, 1994: Interim House of Delegates, Honolulu.

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†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus.* New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol.* 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol.* 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation.* 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology.* 1988;39:1025-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

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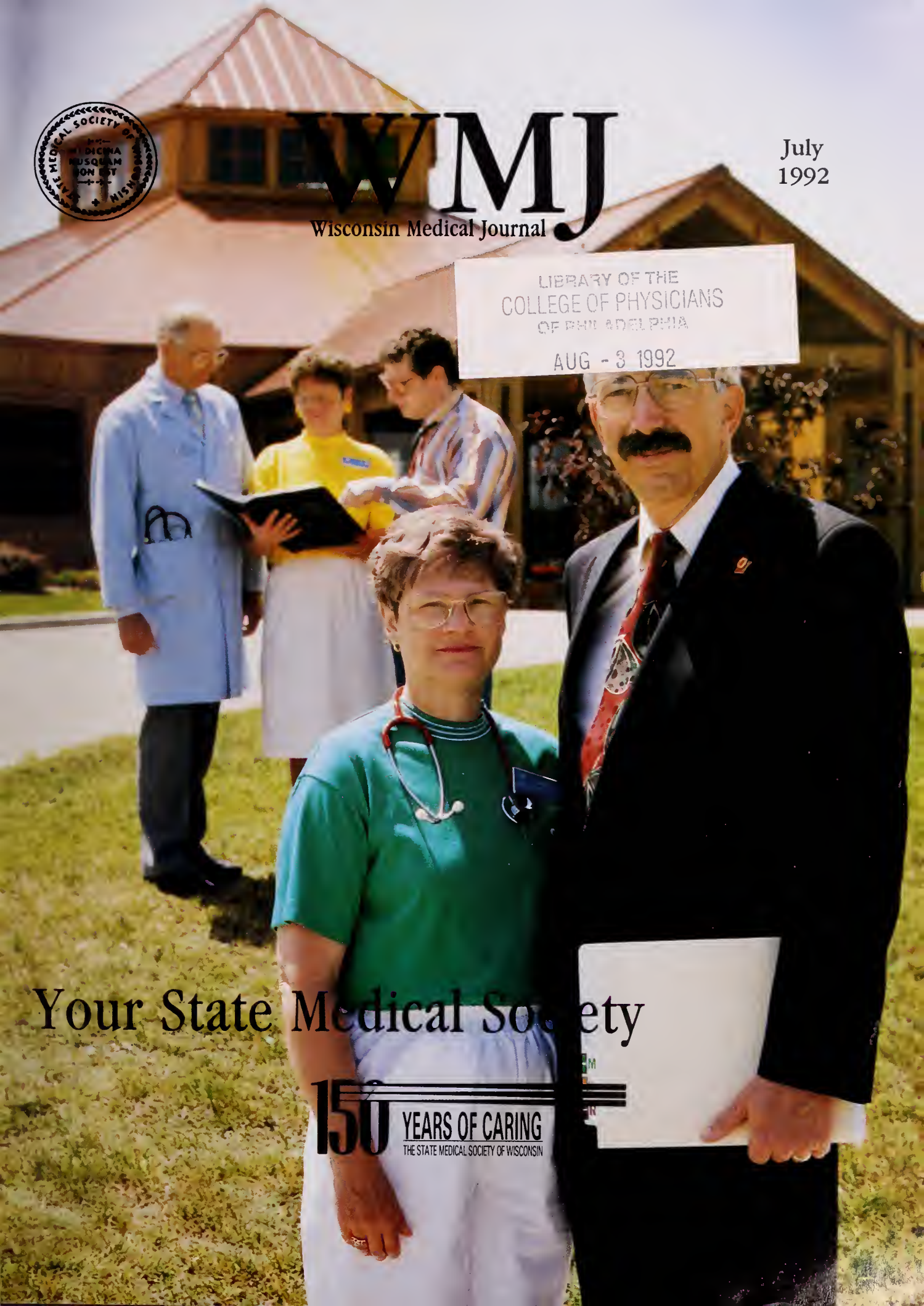
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Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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Contents

July 1992 Vol. 91 No. 7

Opinions

331 *President's page*
Filling station philosophy
by William J. Listwan, MD, West Bend
334 *Secretary's report*
But she's my doctor!
by Thomas L. Adams, CAE, Madison
337 Minnesota's HealthRight not necessarily a disaster
by Stuart R. Lancer, MBA, MD, Eau Claire
338 Kudos from afar
by Wallace Rubin, MD, Metairie, LA
338 *Soundings*
Ad libitum
by Thomas N. Rengel, MD, Wausau

Scientific

343 *Resident writing contest winner*
Lung cancer mortality in Wisconsin: year 2001
by Kenneth T. Bastin, MD, and Minesh P. Mehta, MD, Madison
348 *Student writing contest winner*
The effect of alcohol consumption on body weight among Wisconsin adults
by Kurt Hansen, MD, and Patrick L. Remington, MD, Madison
351 *Graduate nursing student writing contect winner*
Adolescent suicide: an analysis using Erikson's developmental framework
by Janet M. Zimmerman, RN, Madison

Organizational

359 SMS officers and directors: 1992-1993
370 SMS commissions, committees and task forces: 1992-1993
378 Expense reimbursement policy and procedure for physicians on SMS business
379 SMS financial report
380 Charter law of the SMS
381 SMS Constitution and Bylaws
389 Officers of Wisconsin's county medical societies
395 Officers of the SMS specialty and special sections
398 Officers of Wisconsin specialty societies
402 Statewide Physician Health Program
403 Mediation and peer review services
404 SMS physicians' support group
405 Accreditation program for continuing medical education
406 Membership facts
408 SMS officers and directors by district
411 SMS resource directory
414 Publications and reprints available
416 Physician briefs
418 WISPAC and Physicians for Better Government
418 County society news
419 Obituaries
420 AMA awards
421 Saga of SMS secretaries
423 A glimpse into our past
424 Physicians Insurance Company of Wisconsin: state of the corporation

Contents

Annual Meeting

427 House actions on resolutions and reports
432 House of Delegates: 1992
435 *Presidential address*
Health care reform's future: the road less traveled
by Cyril M. "Kim" Hetsko, MD, Madison
439 *Address of the president elect*
The adventure continues
by William J. Listwan, MD, West Bend
443 *Executive vice president's speech*
The search for our future
by Thomas L. Adams, CAE, Madison
446 The fallacy of health care
by Howard Correll, MD, Arena
448 Awards presented at the SMS annual meeting

CES Foundation

453 CESF facts
454 CESF history
454 Foundation grant allocations
455 The Fort Crawford Medical Museum
457 A CESF guide to gifts

Our cover: The Team: Every physician, whether in solo practice or group practice, works along side of, and depends on, other people. Each of these contribute to the care we give our patients. They cover up our weaknesses, emphasize our strengths, and help us to do a better job as physicians.

I depend on my nurse, receptionist, and all the other employees at the General Clinic to help me. I also depend very much on my colleagues who take call for me, cover for me when I'm sick or away, and who do so many things to make my job easier.

Every physician owes a great deal to their supporting team.

-William J. Listwan, MD, West Bend
SMS President 1992-1993

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President's page

Filling station philosophy

EVERY PHYSICIAN has experienced the frustration of patient non-compliance. During the 23 years since I graduated from medical school, I cannot begin to count the number of times that I have had the answer for a patient's problem, but could not convince him or her that it was worth the effort. In some cases, the answer for serious problems was simply a matter of dietary discretion and weight loss. Other times, the answer was more complex involving a surgical procedure, diagnostic test or medication. The answer was either rejected or accepted and then ignored.

During my residency, I convinced myself that I was too easy going and not strident enough with my patients. I felt that, because I didn't pound the table and really make my points forcefully, I was somehow responsible for the lack of compliance that my patients exhibited. In an uncontrolled study, I pounded the table and shouted at the next 10 overweight people who came through my office door with serious medical conditions related to their weight. Nine of the 10 never came back.

The wife of one of these patients, Mrs Hernandez (not her real name), continued to see me for her medical problems. A year later, she confided to me that her husband, Jose, was not feeling well and was having symptoms of chest pain and shortness of breath. He had not seen a doctor since he had last visited me the year before. He wanted to come back and see me but was afraid he would get yelled at again.

She patiently explained to me that being overweight was a cultural sign of good health and also a compliment to the cooking skills of a man's wife. She said that when Jose saw me every couple of months, he tried harder and did better, and was healthier than when left to his own devices. Even though I felt frustrated by my encounters with him, she felt I was really accomplishing some good.

I learned several lessons from this experience. First, I needed to be more aware of the patient's perceptions of my goals and treatments. Not following my advice was not an insult or a sign of lack of confidence in my skills. The failure was partly due to cultural differences and partly due to basic human nature.

Secondly, what I had perceived as a lack of success had been perceived by the

Continued on next page

William J. Listwan, MD

Mini-internship

I WANT TO MAKE SURE that all of you are aware of the "Mini-internship" that will be tried in Wisconsin this year. Two county medical societies, with assistance from the SMS, will try the program which has been used successfully in other states. Our program will involve community leaders, legislators, and physicians spending time together over several days. The legislators and business people will spend a half day with several different physicians learning about the trials and tribulations and joys of medical practice.

This exposure on a one-to-one basis with physicians, and the group reactions that precede and follow the individual internships, have been found beneficial when tried elsewhere. I expect that we will have a similar experience in Wisconsin. If our pilot projects go well, I look forward to expanding this program to other counties in the following years.

Keep your eyes and ears open this year for more information about the program as we move forward.

–William J. Listwan, MD

Continued from preceding page
patient and his wife as beneficial.

Thirdly, and perhaps most importantly, I could not take personal responsibility and blame myself for every non-compliant, or seemingly non-compliant, patient in my practice. If I did, I would either die of a bleeding ulcer or go into a deep depression that might lead to suicide. Neither of these options was appealing to me.

Since I had been a philosophy major in college, I needed to analyze the situation and make some further sense out of it. It was clear to me that with every patient's death, with bad clinical outcomes, and when someone ignores my advice and their condition stays the same or gets worse, a small piece of me is used up. Since my regeneration rate is fixed, I have to be careful not to give up large pieces at the same time or to give up too many small pieces on a regular basis. The result is not enough of me left for myself or my family, a situation that's not beneficial to me or my patients. Since non-compliant patients are fairly common, I had to guard against many small pieces being removed on a regular basis. I subsequently developed what I call my "filling station philosophy" to help me deal with the non-compliant patient.

> 'I am not personally responsible for every failure in my patients' lives.'

The people who come to my office for medical help, whether it's physical or emotional problems that bring them there, are like people who bring their automobiles into a filling station. As a filling station attendant, I can fill up their tank, offer to check the oil, check the air in the tires, clean the windshield, and even give them directions. When they leave the driveway, however, they drive out alone. I cannot go with them. If they decide not to follow my directions and get lost, it's not my responsibility. My responsibility is to give them clear directions. The same thing is true if they ride the clutch, lay rubber at intersections, or mistreat their car in other ways that will shorten its life expectancy.

Although sometimes I have to remind myself, my "filling station philosophy" does work for me. It helps me to deal with the frustrations that I experience on a regular basis as a physician. It helps to remind me of my place in the relationship and to reinforce the idea that I am not personally responsible for every failure in my patients' lives.

* * *

Now, as president of our Medical Soci-

Continued on page 334

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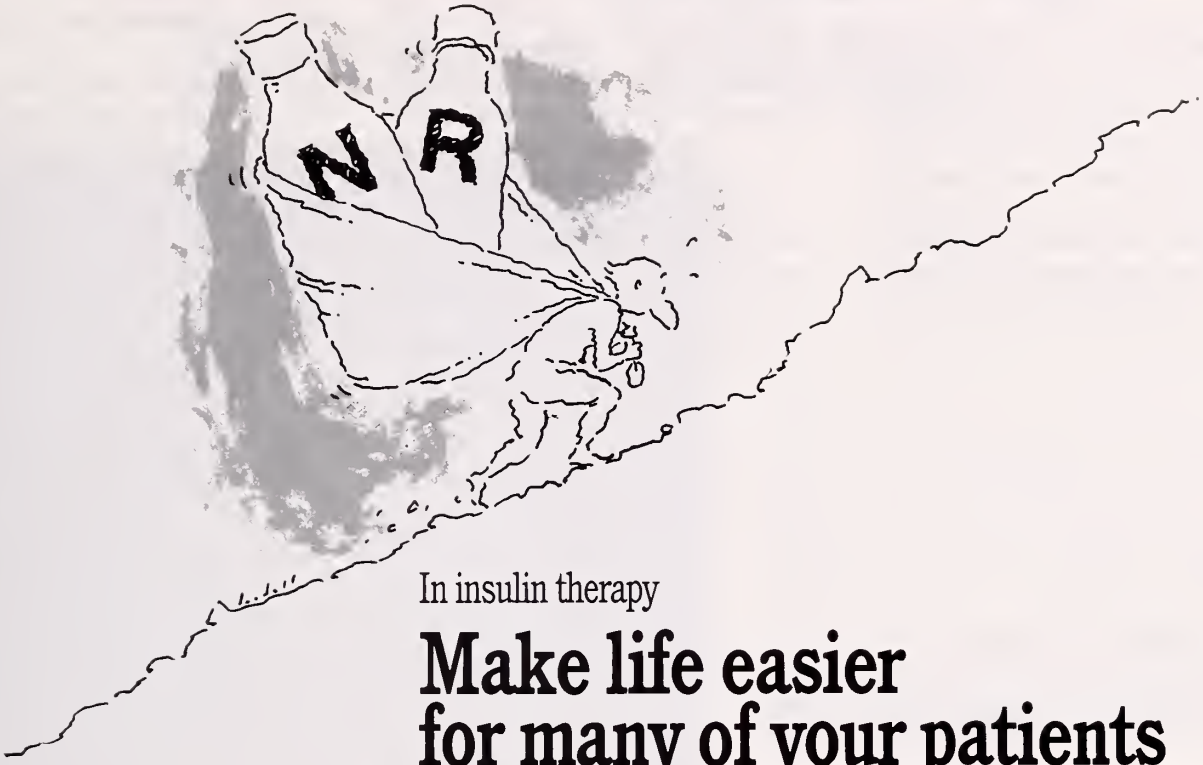

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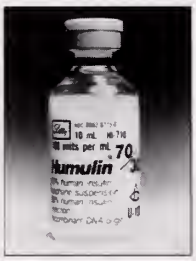

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Continued from page 332
ety I can also see other applications of the "filling station philosophy" in my life. Within our Medical Society, I too frequently see groups of physicians going off in directions that are not beneficial to our common good or, in the long run, not even their own good. I sometimes see physicians inappropriately leaning on the horn or laying rubber, while others are afraid to go the speed limit and ride with one foot constantly on the brake. My job, and the job of clinic leaders, county medical society leaders, and medical staff leaders, is to keep on giving good directions, even when it seems like no one is listening. We do have an effect.

All of you should keep this "filling station philosophy" in mind when dealing with our elected representatives. We need to be thankful that they came to us for information, even if they seem to ignore our advice. In the long run, we do have an effect on them also.

So, for all of the intellectuals, philosophers, and filling station philosophers, a new phrase is added to your lexicon. Remember the "filling station philosophy." Remember it with your patients, with other physicians, and in your political adventures. Let me know what other applications you find for it.

Secretary's report

But she's my doctor!

I RECEIVED THE FOLLOWING letter not too long ago. It was written by a patient whose physician committed suicide, neither of which need to be identified here, and who apparently needed a place to vent some strong emotions and sort out some troubling thoughts. I offer it to you, as the writer suggested, as a reminder. The next time you feel yourself losing faith in your profession, the next time you question yourself, the next time your work seems futile, the next time you're tempted to surrender to the bureaucrats and bean counters who are trying to reduce the physician-patient bond to a mere business transaction: remember that you are somebody's *doctor*. And that still means something.

Dear Mr. Adams:

My doctor killed herself last week.

The news arrived with the sort of jarring force that numbs your brain and evokes the sort of disbelief that bludgeons you dumb. For a long while, all I could do was sit and blink back tears while trying to catch my breath and fighting off the knot twisting up in my chest. When I quit reeling, my thoughts organized themselves into a single, overwhelming response: But she's my *doctor*!

Part of my shock had a philosophical basis: Doctors are dedicated to preserving and enriching life, how could she throw away her own? It simply made no sense.

Part of my shock had a personal basis: I was trusting her, depending on her, to tell me how to live better and longer, how could she desert me? Was I a fool to trust her to help me live a richer life when she was, apparently, unable to do this for herself?

Part of my shock had a basis in fear: If she can't cope with life, how am I supposed to manage? That fear was fueled by my high estimation of my doctor. She was, you must understand, the model physician. Or at least, from this patient's perspective, she appeared to be the model physician.

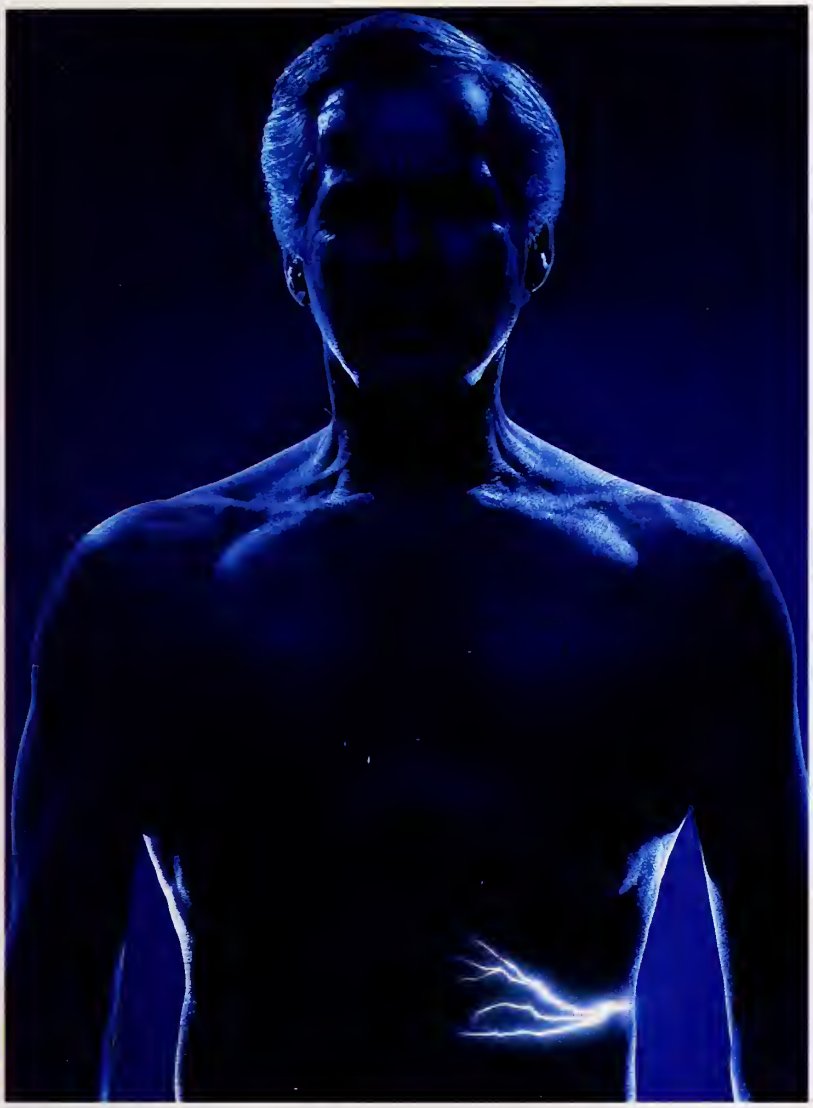
After my first office visit with her, I remarked to several people that this doctor not only struck me as highly intelligent, supremely skilled in medicine and uncompromisingly professional, she made me feel as if she genuinely cared about me. She had time for me and never made me feel rushed. She asked questions. She listened. She responded. She apologized whenever we were interrupted. She joked

Thomas L. Adams, CAE

and laughed with me. She sympathized with my concerns. She was gentle, even when she had to be firm. She asked about my family, my work, my hobbies. She treated me with respect: speaking to me and not at me, considering my ideas, and forthrightly offering her opinions. She made herself understood without being condescending. She seemed as concerned with my emotional health as she was with

Continued on page 337

800 mg tablet for herpes zoster



ZOVIRAX 800 mg 5x/day for 7-10 days significantly reduces the duration of zoster pain[1] and improves clinical outcome.[2,3] Of note, in other studies, when ZOVIRAX was administered at one-half the recommended dose (400 mg 5x/day), efficacy was not significantly different from placebo.[2,4]

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BRIEF SUMMARY

CONTRAINDICATIONS: Zovirax Capsules, Tablets, and Suspension are contraindicated for patients who develop hypersensitivity or intolerance to the components of the formulations. **WARNINGS:** Zovirax Capsules, Tablets, and Suspension are intended for oral ingestion only. **PRECAUTIONS: General:** Zovirax has caused decreased spermatogenesis at high parenteral doses in some animals and mutagenesis in some acute studies at high concentrations of drug (see PRECAUTIONS — Carcinogenesis, Mutagenesis, Impairment of Fertility). The recommended dosage should not be exceeded. Exposure of herpes simplex and varicella-zoster isolates to acyclovir *in vitro* can lead to the emergence of less sensitive viruses. The possibility of the appearance of less sensitive viruses in man must be borne in mind when treating patients. The relationship between the *in vitro* sensitivity of herpes simplex or varicella-zoster virus to acyclovir and clinical response to therapy has yet to be established (see full prescribing information). Because of the possibility that less sensitive virus may be selected in patients who are receiving acyclovir, all patients should be advised to take particular care to avoid potential transmission of virus if active lesions are present while they are on therapy. In severely immunocompromised patients, the physician should be aware that prolonged or repeated courses of acyclovir may result in selection of resistant viruses which may not fully respond to continued acyclovir therapy. Caution should be exercised when administering Zovirax to patients receiving potentially nephrotoxic agents since this may increase the risk of renal dysfunction. **Drug Interactions:** Co-administration of probenecid with intravenous acyclovir has been shown to increase the mean half-life and the area under the concentration-time curve. Urinary excretion and renal clearance were correspondingly reduced. The clinical effects of this combination have not been studied. **Carcinogenesis, Mutagenesis, Impairment of Fertility:** The data presented below include references to peak steady state plasma acyclovir concentrations observed in humans treated with 800 mg given orally 6 times a day (dosing appropriate for treatment of herpes zoster) or 200 mg given orally 6 times a day (dosing appropriate for treatment of genital herpes). Plasma drug concentrations in animal studies are expressed as multiples of human exposure to acyclovir at the higher and lower dosing schedules (see full prescribing information). Acyclovir was tested in lifetime bioassays in rats and mice at single daily doses of up to 450 mg/kg administered by gavage. There was no statistically significant difference in the incidence of tumors between treated and control animals, nor did acyclovir shorten the latency of tumors. At 450 mg/kg/day, plasma concentrations were 3 to 6 times human levels in the mouse bioassay and 1 to 2 times human levels in the rat bioassay. Acyclovir was tested in two *in vitro* cell transformation assays. Positive results were observed at the highest concentration tested (31 to 63 times human levels) in one system and the resulting morphologically transformed cells formed tumors when inoculated into immunosuppressed, syngeneic, weanling mice. Acyclovir was negative (40 to 80 times human levels) in the other, possibly less sensitive, transformation assay. In acute cytogenetic studies, there was an increase, though not statistically significant, in the incidence of chromosomal damage at maximum tolerated parenteral doses of acyclovir (100 mg/kg) in rats (62 to 125 times human levels) but not in Chinese hamsters; higher doses of 500 and 1000 mg/kg were clastogenic in Chinese hamsters (380 to 760 times human levels). In addition, no activity was found after 5 days dosing in a dominant lethal study in mice (36 to 73 times human levels). In all 4 microbial assays, no evidence of mutagenicity was observed. Positive results were obtained in 2 of 7 genetic toxicity assays using mammalian cells *in vitro*. In human lymphocytes, a positive response for chromosomal damage was seen at concentrations 150 to 300 times the acyclovir plasma levels achieved in man. At one locus in mouse lymphoma cells, mutagenicity was observed at concentrations 250 to 500 times human plasma levels. Results in the other five mammalian cell loci follow: at 3 loci in a Chinese hamster ovary cell line, the results were inconclusive at concentrations at least 1850 times human levels; at 2 other loci in mouse lymphoma cells, no evidence of mutagenicity was observed at concentrations at least 1500 times human levels. Acyclovir has not been shown to impair fertility or reproduction in mice (450 mg/kg/day, p.o.) or in rats (25 mg/kg/day, s.c.). In the mouse study plasma levels were 9 to 18 times human levels, while in the rat study they were 8 to 15 times human levels. At a higher dose in the rat (50 mg/kg/day, s.c.), there was a statistically significant increase in post-implantation loss, but no concomitant decrease in litter size. In female rabbits treated subcutaneously with acyclovir subsequent to mating, there was a statistically significant decrease in implantation efficiency but no concomitant decrease in litter size at a dose of 50 mg/kg/day (16 to 31 times human levels). No effect upon implantation efficiency was observed when the same dose was administered intravenously (53 to 106 times human levels). In a rat peri- and postnatal study at 50 mg/kg/day s.c. (11 to 22 times human levels), there was a statistically significant decrease in the group mean numbers of corpora lutea, total implantation sites and live fetuses in the F_1 generation. Although not statistically significant, there was also a dose-related decrease in group mean numbers of live fetuses and implantation sites at 12.5 mg/kg/day and 25 mg/kg/day, s.c. The intravenous administration of 100 mg/kg/day, a dose known to cause obstructive nephropathy in rabbits, caused a significant increase in fetal resorptions and a corresponding decrease in litter size (plasma levels were not measured). However, at a maximum tolerated intravenous dose of 50 mg/kg/day in rabbits (53 to 106 times human levels), no drug-related reproductive effects were observed. Intraperitoneal doses of 80 or 320 mg/kg/day acyclovir given to rats for 6 and 1 months, respectively, caused testicular atrophy. Plasma levels were not measured in the one month study and were 24 to 48 times human levels in the six month study. Testicular atrophy was persistent through the 4-week postdose recovery phase after 320 mg/kg/day; some evidence of recovery of sperm production was evident 30 days postdose. Intravenous doses of 100 and 200 mg/kg/day acyclovir given to dogs for 31 days caused aspermatogenesis. At 100 mg/kg/day plasma levels were 47 to 94 times human levels, while at 200 mg/kg/day they were 159 to 317 times human levels. No testicular abnormalities were seen in dogs given 50 mg/kg/day i.v. for one month (21 to 41 times human levels) and in dogs given 60 mg/kg/day orally for one year (6 to 12 times human levels). **Pregnancy: *Teratogenic Effects:*** Pregnancy Category C. Acyclovir was not teratogenic in the mouse (450 mg/kg/day, p.o.), rabbit (50 mg/kg/day, s.c. and i.v.) or in standard tests in the rat (50 mg/kg/day, s.c.). These exposures resulted in plasma levels 9 and 18, 16 and 106, and 11 and 22 times, respectively, human levels. In a non-standard test in rats, there were fetal abnormalities, such as head and tail anomalies, and maternal toxicity. In this test, rats were given 3 s.c. doses of 100 mg/kg acyclovir on gestation day 10, resulting in plasma levels 63 and 125 times human levels. There are no adequate and well-controlled studies in pregnant women. Acyclovir should not be used during pregnancy unless the potential benefit justifies the potential risk to the fetus. Although acyclovir was not teratogenic in standard animal studies, the drug's potential for causing chromosome breaks at high concentration should be taken into consideration in making this determination. **Nursing Mothers:** Acyclovir concentrations have been documented in breast milk in two women following oral administration of Zovirax and ranged from 0.6 to 4.1 times corresponding plasma levels. These concentrations would potentially expose the nursing infant to a dose of acyclovir up to 0.3 mg/kg/day. Caution should be exercised when Zovirax is administered to a nursing woman. **Pediatric Use:** Safety and effectiveness in children have not been established. **ADVERSE REACTIONS–Herpes Simplex: *Short-Term Administration:*** The most frequent adverse reactions reported during clinical trials of treatment of genital herpes with orally administered Zovirax were nausea and/or vomiting in 8 of 298 patient treatments (2.7%) and headache in 2 of 298 (0.6%). Nausea and/or vomiting occurred in 2 of 287 (0.7%) patients who received placebo. Less frequent adverse reactions, each of which occurred in 1 of 298 patient treatments with orally administered Zovirax (0.3%), included diarrhea, dizziness, anorexia, fatigue, edema, skin rash, leg pain, inguinal adenopathy, medication taste and sore throat. **Long-Term Administration:** The most frequent adverse reactions reported in a clinical trial for the prevention of recurrences with continuous administration of 400 mg (two 200 mg capsules) 2 times daily for 1 year in 586 patients treated with Zovirax were: nausea (4.8%), diarrhea (2.4%), headache (1.9%) and rash (1.7%). The 589 control patients receiving intermittent treatment of recurrences with Zovirax for 1 year reported diarrhea (2.7%), nausea (2.4%), headache (2.2%) and rash (1.5%). The most frequent adverse reactions reported during the second year by 390 patients who elected to continue daily administration of 400 mg (two 200 mg capsules) 2 times daily for 2 years were headache (1.5%), rash (1.3%) and paresthesia (0.8%). Reactions reported by 329 patients during the third year include asthenia (1.2%), paresthesia (1.2%) and headache (0.9%). **Herpes Zoster:** The most frequent adverse reactions reported during three clinical trials of treatment of herpes zoster (shingles) with 800 mg of oral Zovirax 5 times daily for 7 to 10 days in 323 patients were: malaise (11.5%), nausea (8.0%), headache (5.9%), vomiting (2.5%), diarrhea (1.5%) and constipation (0.9%). The 323 placebo recipients reported malaise (11.1%), nausea (11.5%), headache (11.1%), vomiting (2.5%), diarrhea (0.3%) and constipation (2.4%). **Observed During Clinical Practice:** Based on clinical practice experience in patients treated with oral Zovirax in the U.S., spontaneously reported adverse events are uncommon. Data are insufficient to support an estimate of their incidence or to establish causation. These events may also occur as part of the underlying disease process. Voluntary reports of adverse events which have been received since market introduction include: ***General:*** fever, headache, pain, peripheral edema ***Digestive:*** diarrhea, elevated liver function tests, gastrointestinal distress, nausea ***Hemic and Lymphatic:*** leukopenia, lymphadenopathy ***Nervous:*** confusion, dizziness, hallucinations, paresthesia, somnolence ***Musculoskeletal:*** myalgia ***Skin:*** alopecia, pruritus, rash, urticaria ***Special Senses:*** visual abnormalities

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IMPROVING LIVES THROUGH ANTIVIRAL RESEARCH

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Continued from page 334
my physical health. I felt about my doctor the way I would feel about a trusted friend, and those first impressions never changed. Well, at least not until I heard the news.

Now, the thought keeps coming back to me: If she can't make it, what is to become of the rest of us? All of us have different supplies of tools and levels of skills with which we try to get ourselves past life's rough spots, but my physician seemed to have more than most of us. She had brains, education, a secure income, good health, concern for others, the respect of her peers, the gratitude of her patients, and both the ability and opportunity to make the world a better place. I know nothing of her personal life, but how likely is such a person to fail to earn the love of her friends and family? And if that isn't a description of a life worth living, what is? Are not the satisfactions of being a good person among common folk great enough to sustain us anymore? If a person so wealthy in the things that matter cannot survive life's blows, what chance do we lesser fellows have?

Maybe she was too sick to be helped and couldn't face a long and painful death. Maybe she was lost and didn't know how to ask for help. Surrounded every day by people trained to rescue others, she should have found it easy to get help. Maybe doctors think they must only give and never take. Maybe they're afraid others will think poorly of them if they admit to being human, to having weaknesses and illnesses. I don't know. I do know I will miss her.

'Maybe doctors think they must only give and never take.'

I do not know what specters haunted the psyche of my doctor and drove her to this end, nor do I know what to do with my feelings of anger, confusion, betrayal and fear. So, I'm writing to you. Maybe you can help doctors get the care they need for themselves. Maybe you can tell them that they are more to us than just a source for pills and sutures. Maybe you can let them know that we think of them as much, much more.

* * *

This patient's letter made more than one point worth considering, but I'd like to emphasize one from that final paragraph. As physicians, you take it as a matter of course to help others, but it is crucial that you also help yourself. Take time for yourself and your family. Monitor your own health, physical and emotional, as you would the health of another. Resist the temptation, so common among health care professionals, to stretch yourself just a little bit farther, to sacrifice for your patients just a little bit more. If you need to put it in terms that sound less selfish, fine: There are people counting on you, and if you neglect yourself, you neglect them.

If you find yourself overwhelmed, reach out and ask for help. Please. The SMS Statewide Physician Health Program and the SMS Committee on Alcohol and Other Drug Abuse are available if you need their services. Turn to whomever you are most comfortable with–family, friends, peers, mentors, clergy, your own physician–but turn to someone. As we have seen, what you do matters.[150th]

Minnesota's HeathRight not necessarily a disaster

To the editor: Although certainly not a proponent of the HealthRight Bill recently passed in Minnesota, I am somewhat disturbed by the recent commentary on the bill by SMS Executive Vice President Thomas Adams ("For whom the bell tolls," *Wis Med J.*1992;91(4):164-166). While I certainly agree that the HealthRight Bill is not perfect and has some definite problems, I believe Adams' suggestion that this bill "has the potential for turning the play of health care reform into a tragedy," is greatly overstated.

I cannot believe that Adams is so distressed by the concept of health care rationing. Health care rationing is currently a fact of life throughout the United States. Unfortunately, however, health care rationing today is not based on any societal consensus but is arbitrary and based mostly on one's economic and political status.

Additionally, Adams exaggerates when he states HealthRight will put an immediate freeze on all new technology. The bill only requires that new technology must first be approved by the HealthRight Commission. It makes perfect sense to me that we evaluate new technology prior to its introduction into the mainstream of medicine. We should not just question if new technology is more expensive but also whether it offers any additional benefits above current technology. In other words, does the new technology have greater value. Currently, there is little evaluation of new technology prior to it being introduced into everyday medical practice. There are many examples of technology that has become commonplace in health care only to be found out later to offer no advantage or to increase costs proportionally more than any benefits derived.

Continued on next page

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I certainly agree with Adams that it would be wise to have more physicians members of the commission, but I trust that our neighbors to the west will be enlightened enough to appoint knowledgable and reasonable individuals."

Additionally, if Adams thinks that we can separate politics from health care spending, I suggest he has not been very observant at what has been going on in this country for the past 10 years. Certainly, Minnesota's commission will not be free from political pressures, but that, for better or for worse, is the way our country operates.

In regard to HealthRight limiting the number of specialists in the state of Minnesota, I think that is a policy for which the time has come. Almost every other country in the world has approximately 80% generalists and 20% specialists. In the United States, it is ludicrous that this ratio is almost reversed. Many feel that this lack of generalists and excess of specialists in the United States is one of the leading causes for escalating health care costs. The extreme difficulty in recruiting family practice and other primary care doctors in Wisconsin is a result of this maldistribution.

Although HealthRight is not the perfect bill and will probably need to be modified, it has some good provisions and is not the disaster that Adams makes it out to be.

–Stuart R. Lancer, MBA, MD
Eau Claire[150th]

Kudos from afar

To the Editor: I commend you on your commentary titled "Physicians have always offered free health care to needy." I have been saying this for a number of years now but hardly anybody's listening. All of this commotion about the needy not getting health care began when the "great society" passed the Hill/Burton Act and provided funds for all kinds of things including taking care of the needy. All of us have been doing this for years and continue to do this and the public really isn't aware of it. Your article should appear in all of the daily newspapers in addition to the *American Medical News.*

Congratulations once again.

–Wallace Rubin, MD
Metairie, La

Editor's Note: The writer refers to the *AMA News* reprinting of Thomas L. Adams' "Secretary's report: There's nothing like a cheap shot." *Wis Med J.* 1992;91(2):60-62.[150th]

Soundings
Ad libitum

Thomas N. Rengel, MD, Wausau

"Collective action by independently practicing physicians can violate US anti-trust laws unless physicians proceed very cautiously.

Case in point

In a recent medical society meeting, during the discussion of a proposed HMO agreement, several doctors said they would not participate in the plan unless the payor increased reimbursement. If a substantial number of physicians later declined to participate in the HMO, the medical society and its members could be sued and a jury could find them guilty of a group boycott in violation of US anti-trust laws.

Case in point

Have you ever discussed your fees with another physician? Or have you ever shared your feelings about an HMO or a PPO plan with other physicians in town? Unless the doctors you talked to were your partners, you may have violated US anti-trust laws and could face criminal prosecution. If found guilty of price-fixing or group boycott, you could be fined, sentenced and stripped of your license."

The above admonitions are part of advertisements for a booklet promoted by the AMA. Physicians need to know that actions of the type described above are presently outlawed and, indeed, are thankful for the AMA advice. By now, unless one has been living in a leukemia-bubble, I suppose we are all not only aware of this but have been sufficiently beaten by this information, and the attitude that it implies, that there is little left of our morale.

Thank you, AMA, for lending your voice to the government's, that freedom of speech applies to certain individuals under certain circumstances but not to all of us and certainly not to independently practicing physicians.

I believe the more appropriate posture the AMA should take is to adamantly demand that legislation be enacted to

Continued on page 340

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Continued from page 338

protect the legitimate first amendment rights of an individual to say whatever he wishes to say in private or in public. As far as limitations on this are concerned, even speech demanding the overthrow of the government is protected in this country.

An incredibly oppressive bureaucracy has deemed it appropriate to limit physicians' discussions about equally oppressive methods and actions of certain HMOs and PPOs and the government's own reimbursement company. Rather than an advertisement by the AMA smacking of complicity in this oppression, our largest national medical association should cry out in disbelief and rage and do everything in its power to get this activity abolished.

None of us believe we are free to engage in conspiracy and price fixing that will deprive other legitimate physician groups of their ability to practice medicine. But to tie our hands behind our backs while these other conspirators are free to reign holy terror on the independent practice of medicine in this country and while the government arbitrarily determines our charges, even to the point of driving people out of the practice of medicine in some cases, is patent tyranny.

The AMA wishes to have our confidence and financial support. I suggest that its leadership take a closer look at the US Constitution and Bill of Rights in an attempt to assure that, at least, physicians are being assured basic civil rights. We certainly do not need the AMA to unwittingly assist in outrageous attempts to frighten physicians into compliance with discriminatory administration of US antitrust laws, which were designed to protect independent and small business enterprises from the unfair practices of large monopolizing concerns. It is obvious to almost everybody except the Federal Trade Commission (and the AMA?) that the FTC is acting in a manner diametrically opposite to the spirit of the laws it is enforcing.

The AMA must concentrate on returning basic rights to physicians. This has to include working toward changes in the system of justice in this country which has every physician working in a defensive manner that is easily doubling the cost of medical care. The Kafkaesque system of scrutinizing every move a physician makes has further contributed to burgeoning medical bureaucracy, so costly that it is forcing the entire country to acquiesce to a predictably onerous, unwieldy, and even more costly system of national health care.

Where does the AMA stand on this issue? It appears to believe we truly are scoundrels or that we must admit to it to keep peace with Fortney Stark and similar henchmen.

And what about ethical issues?

The AMA pushes seatbelt laws, antitobacco laws, drinking laws and environmental laws. There are plenty of legitimate interest groups with credibility working on these matters. They hardly need the help of the AMA in our increasingly busy-body society.

The real ethical issues have more to do with how interest groups have such a profound influence on the AMA that the real medical issues of the day are ignored or obfuscated. Whether we like it or not, the wrenching questions of abortion and euthanasia will have to be addressed. Is the AMA concerned that its leadership is speaking for physicians who have taken the time to historically and philosophically examine these matters rather than simply polling the constituency on how they "feel" at any point in time?

The AMA's answer has been to promote a new "Hippocratic oath," in which references to "respect for life from conception," and, never administering a nostrum that will take a patient's life, are deleted. That attitude toward ethics lies somewhere between ignorance and the practice of re-writing history to accommodate political prejudices as is alleged of the post-Lenin Soviet Union.

More and more frequently, I hear physicians express the idea that the AMA simply does not speak for them and is not representing our medical business and ethical interests. It has become so involved in political gainsmanship that the basic principles upon which the practice of medicine is based and the raison d'etre of a medical association are lost.

The patent response of AMA leaders and spokespersons is that "the AMA is our strongest voice. Even if imperfect, it is all we have."

There is a kernel of truth in this argument, but it's present posture makes it difficult for many of us to distinguish the AMA from the opposition.

These days it seems to be more an arm of the government's policies of subjugation, harassment and terror with perpetual talk of policing ourselves, complicity with FTC regulations and working toward meaningless subtle changes in HCFA policies when the entire attitude of government interference needs to be severely contested.

And who is going to lead in the examination of the issue of the sanctity of human life from its start to its finish when "our strongest voice" equivocates or hides from such issues? This is the very basis upon which medicine has stood throughout its history. When basic principles are abandoned, they are replaced by "values" which change like the winds and have no more validity than last week's opinion polls.

Opinion policy

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Resident writing contest winner

Lung cancer mortality in Wisconsin: year 2001

Kenneth T. Bastin, MD, and Minesh P. Mehta, MD, Madison

Lung cancer is the major cause of cancer mortality in Wisconsin, with an estimated 2,300 deaths in 1991. The low 5-year survival rate of about 10% in lung cancer is primarily attributed to advanced inoperable stage at diagnosis, limited response to therapy, and a high incidence of metastatic spread. Since smoking is the major etiologic factor associated with lung cancer, this is a largely preventable disease. Many current smokers may already have severe bronchopulmonary dysplasia or neoplastic changes that may manifest many years later. We report on a model developed to evaluate the effect of improved therapy for lung cancer patients in the next decade. Based on this model, Wisconsin's projected lung cancer mortality is estimated at 2,117 in the year 2001, without improved treatment, resulting in nearly 25,000 "years of potential life lost." According to this model, a 10% reduction in lung cancer mortality plus a 12-month increase in palliation in the year 2001 will "regain" more years of potential life lost than the current mortality for stomach, cervical, or uterine cancer. Thus, improved cure and palliation for lung cancer patients represents an important goal for Wisconsin's medical community. *Wis Med J.* 1992;91(7):343-347.

Lung cancer is the major cause of cancer mortality in the United States, with 161,000 new cases and 143,000 deaths estimated nationwide for 1991, of which 2,300 (1.6%) were from Wisconsin.[1] The high mortality of lung cancer is a consequence of advanced stage at diagnosis (Table 1).[2] The overall 5-year survival rate for lung cancer is approximately 10%. Gender, histology, stage, and performance status are important prognostic factors.[3]

Smoking is thought to have been responsible for the premature death of 390,000 Americans in 1988[4] and is linked to approximately 90% of lung cancer cases.[5,6] The latency period for the clinical diagnosis of lung cancer may be 20 years,[5] and evidence suggests that the lung cancer risk may begin to decline 5 years after smoking cessation.[7] Cigarette smoking in the United States, particularly among white males, has shown a recent downward trend.[8] Smoking prevalence in the United States in 1985 was 30.4%, with the Wisconsin average being 26%.[9]

To characterize the therapeutic challenge awaiting Wisconsin surgeons, pulmonologists, and oncologists in 2001, a smoking-adjusted projection of lung cancer mortality in Wisconsin is presented, along with "years of potential life lost" (YPLL) estimates. The statewide effect of improved therapy for lung cancer is discussed.

Materials and methods

Demographics. Population projections for 2001 in Wisconsin were determined by linear interpolation of predicted estimates for 2000 and 2005[10] and were stratified according to age and sex. The 1990 racial composition of Wisconsin was used.[11]

Smoking. Smoking prevalence in the United States between 1974-1985 has been analyzed for gender and race.[8] Since this analysis deals with the incidence of lung cancer in Wisconsin in 1988 and

Table 1.—Stage of disease at presentation

Stage	% of patients	5 year survival male	5 year survival female
local	17	28	51
regional	22	10	15
distant	48	~0	~0
total	-	8	13

Data from Cancer Patient Survival, Report No 5, DHEW, 1977, (NIH), 77-912.

The authors are with the Department of Human Oncology at the University of Wisconsin Hospitals and Clinics in Madison. Reprint request to: Kenneth T. Bastin, MD, K4/B100, University of Wisconsin, 600 Highland Drive, Madison, WI 53792. Copyright 1992 by the State Medical Society of Wisconsin.

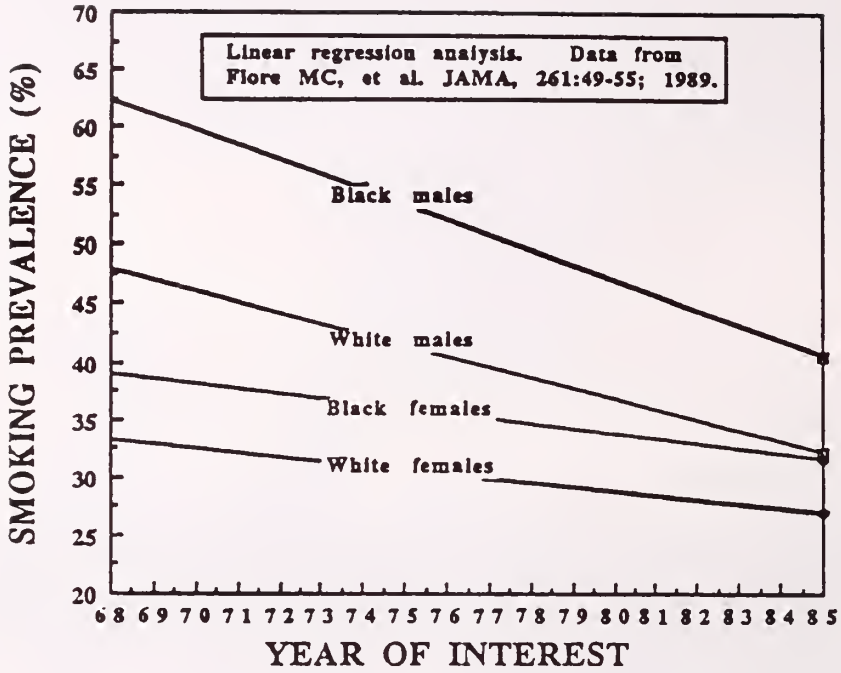

Fig 1.–Smoking prevalence in the United States for 1968-1985 shows a downward trend. Smoking among men has dropped significantly more than females in the plotted period.

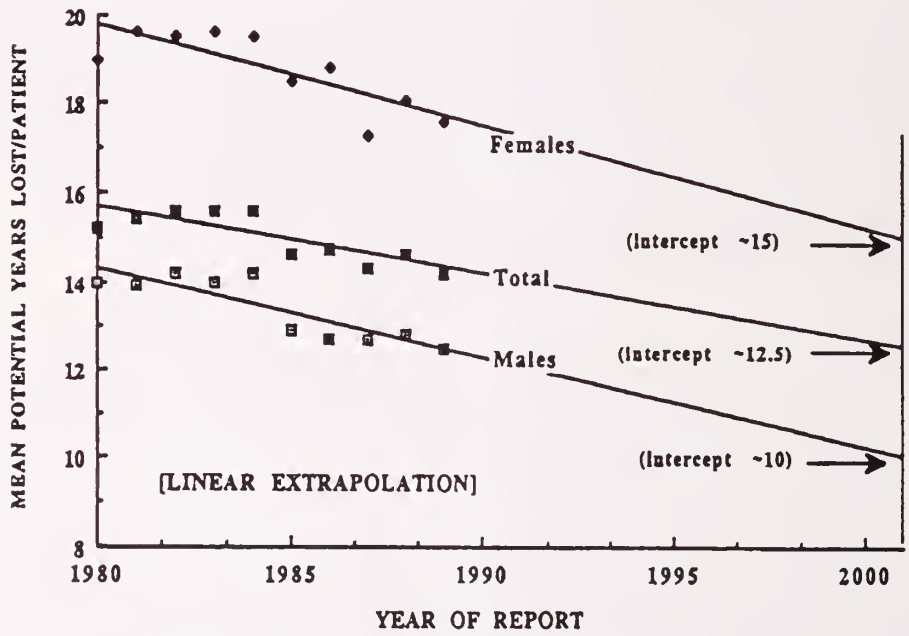

Fig 2–Linear extrapolation of the mean years of potential life lost per Wisconsin lung cancer patient (1980-1989) produces a continuing downward trend to the year 2001.

2001, it was necessary to estimate smoking prevalence 20 years prior to these dates. These data were obtained by regression analysis of published data (Figure 1).[10] The racial and gender data comparison of Wisconsin[11] were used to estimate overall smoking prevalence in those years.

Lung cancer mortality. The 1988 Wisconsin lung cancer mortality rates adjusted for age group were applied to the projected 2001 population.[12] The 1968 and 1981 smoking rates were then compared. Assuming that 90% of lung cancers are attributed to smoking, 2001 mortality rates were reduced by 0.9 times the percent decrease in smoking prevalence between 1968 and 1981, and weighted according to race and gender composition (Table 2).

Table 2.–Lung cancer mortality in Wisconsin year 2001*

Age group	# Male	# Female
<45	25	16
45-49	32	20
50-54	69	44
55-59	122	93
60-64	223	91
65-69	223	138
70-74	286	128
75-79	216	95
80-84	117	67
85+	80	32
Subtotal	1393	724
Total	2117	

*Smoking adjusted

Years of potential life lost. The calculated YPLL for lung cancer mortality in Wisconsin has been published for 1980-1989[12] and was determined by summing the difference between age at death from lung cancer and normal life expectancy:

$$\text{YPLL} = \sum_{1}^{n} [\text{life expectancy-age at death}]$$

Because life expectancy data for 2001 are unavailable, an average YPLL per patient (stratified for gender) was calculated for 1980-1989. Linear extrapolation projected the YPLL per patient for the year 2001 (Figure 2). Multiplying these interpolated figures by the projected mortality figures for 2001 produced an estimated YPLL for lung cancer in Wisconsin in 2001.

Results

Demographics and smoking. The approximate 5,060,000 Wisconsin residents in the year 2001 will be older and pre-

Table 3.–Factors influencing lung cancer incidence in Wisconsin.

1. Change in prevalence, frequency, and type of smoking.
2. Migration of high risk state residents to other states.
3. Changes in patient comorbidity or non-cancer mortality.
4. Progression of median age of high risk patients who may die from comorbid disease before clinical diagnosis.
5. Development of accurate screening tests, diagnosing patients who may not otherwise attain clinical symptoms.
6. Reduction in second-hand smoke, radon, or other environmental carcinogen exposure.

Table 4.–Factors influencing mortality of lung cancer in Wisconsin.

1. Development of an accurate screening method for high-risk patients, allowing for earlier and more effective therapy.
2. Improved therapy for advanced stage lung cancer.
3. Demographic changes in lung cancer stage or histology.
4. Decreased co-morbidity of patients.
5. Changes in access to appropriate cancer therapy.

dominantly white (~90%). Smoking among white males (46% of population) and black males (2.5% of population) between 1968 and 1981 dropped 9.8% (weighted average). A smaller drop among females during the same period was seen (3.6%).

Lung cancer mortality projections. The smoking-adjusted mortality figures for the 2001 population are shown in Table 2. The projected 2,117 lung cancer deaths in Wisconsin for year 2001 (Figure 3) represents a slight drop in the current mortality figure.[12,13] An increase in lung cancer mortality numbers among aging Wisconsinites mirrors the expanding older population. The gender gap for lung cancer mortality will also narrow, corresponding to the sharper drop in smoking prevalence among males between 1968 and 1981.

Table 5.–Years regained from improved cancer therapy.

Mortality change	Cancer type	Potential years regained*
decrease in mortality of lung cancer	10% mortality decrease	2,479
	5% mortality decrease	1,238
	1% mortality decrease	248
	6 month improved survival	1,060
	12 month improved survival	2,117
50% decrease in mortality	leukemia	3,137
	lymphoma	1,575
	pancreas	2,662
	prostate	2,654
0% mortality	stomach	3,501
	uterus	1,490
	cervix	1,203

*Note: Lung figures based on 2001 projections; non-lung sites based on years of potential life lost, 1988.

Years of potential life lost. The product of the extrapolated mean YPLL per patient and the gender-weighted mortality estimates yield the projected statewide YPLL for the year 2001 (Figure 4). A total 24,790 YPLL in 2001 represents a 24% drop in YPLL compared to 1988.[12]

Discussion

Lung cancer will be the leading cause of cancer death in Wisconsin for the next several years. In addition, the YPLL for lung cancer will continue to exceed all other cancers in Wisconsin. The low cure rate of lung cancer (~10%) is reflective of biologically aggressive tumor behavior, critical anatomic location, and advanced stage at presentation.

Reduction of lung cancer morbidity and mortality has remained a high priority among cancer specialists. Smoking cessation and prevention programs are thought to be the most efficient and effective means to reduce the future incidence of lung cancer. The current use of low tar, filtered cigarettes may reduce the carcinogenic exposure and subsequently reduce the incidence of lung cancer. Increased smoking costs and limited public sites for smoking may reduce tobacco consumption and the risk for lung cancer. A reduction in exposure to radon, secondary smoke, and other environmental carcinogens will have only a slight impact on the future incidence of lung cancer. Table 3 lists some factors affecting the incidence of lung cancer in Wisconsin.

Lung cancer survival is related to stage at diagnosis and tumor histology. Squamous cell carcinoma is typically associated with a higher 5-year survival (20%) than small cell carcinoma (<5%), which is frequently disseminated at the time of diagnosis. Although local control can be achieved using radiotherapy or surgical resection, at least 50% of lung cancer patients will subsequently develop incurable metastatic disease.

Currently, no cost-effective measures are available for early detection of lung cancer. A large screening study using

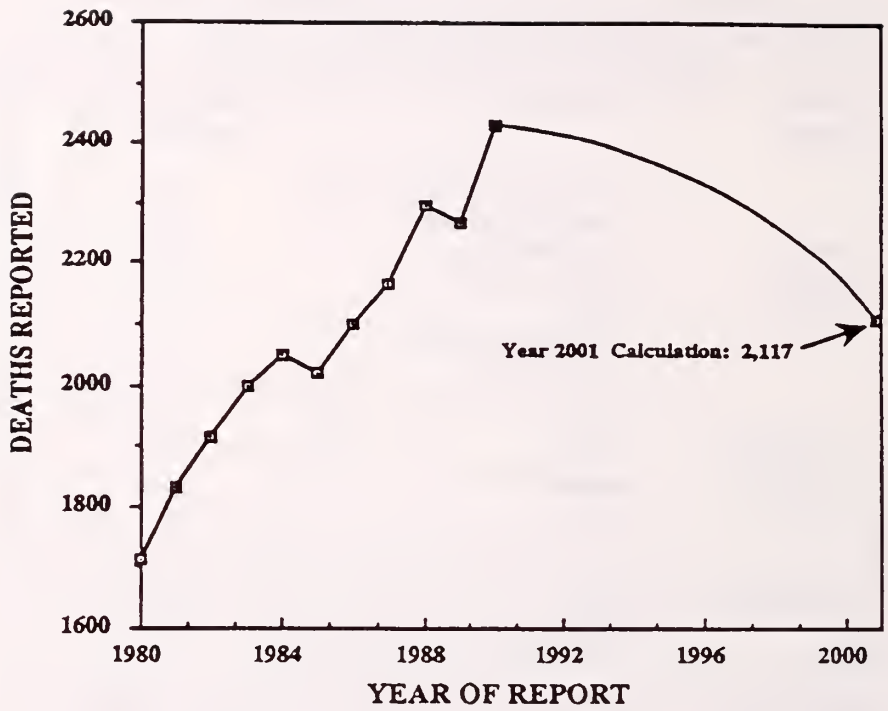

Fig 3.—Published yearly mortality figures for lung cancer in Wisconsin (1980-1989) are plotted along with the year 2001 projection.

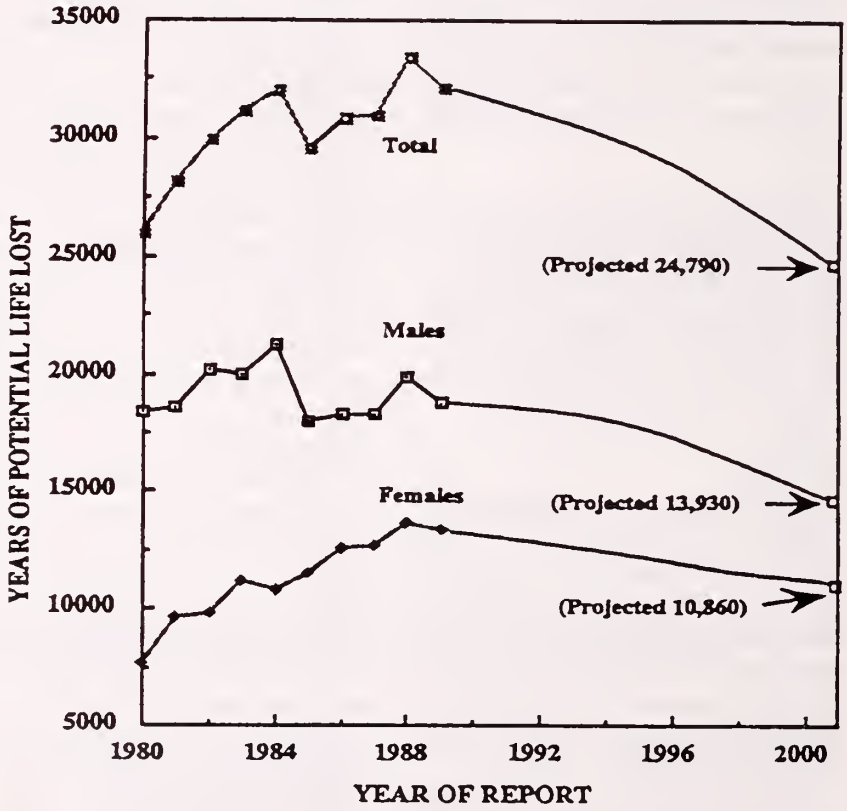

Fig 4.—Total years of potential life lost for lung cancer in Wisconsin (1980-1989) are plotted along with the year 2001 projection.

sputum cytology sampling and chest x-rays involving more than 31,000 male smokers older than 45 years did not alter the group's mortality from lung cancer.[14] Table 4 lists some factors that may alter future lung cancer mortality in Wisconsin.

How then do we reduce mortality among the more than 2,000 Wisconsin residents who will be diagnosed with lung cancer in the year 2001? Some reduction in lung cancer incidence may be achieved by immediate smoking cessation, but many future lung cancer patients likely have already developed severe bronchopulmonary dysplasia or early neoplastic transformation. Thus, in the absence of an accurate and reliable screening method for these high risk patients, improved curative or palliative therapy will be essential for any reduction in lung cancer mortality.

Several assumptions and extrapolations have been used in our analysis to project lung cancer mortality and subsequent "years of potential life lost" for Wisconsin in the year 2001. Population projections were obtained from available Wisconsin data, and age and sex-specific lung cancer mortality rates for 1988 were directly applied to the projected 2001 population. Lung cancer incidence was assumed to directly reflect smoking patterns 20 years prior to the index year. Sex and race-specific trends in smoking for the years 1968 and 1981, derived using linear regression of available data, permitted lung cancer mortality rates to be "smoking adjusted." Changes were weighted by 0.9, since 90% of lung cancer is assumed to be directly associated with smoking. Years of potential life lost (YPLL) per lung cancer patient was then determined for the years 1980-1989 in Wisconsin, and showed a downward trend, implying an increased median age at diagnosis, improved curative and palliative therapy, minimal gains in normal life expectancy, or a combination thereof.

An extrapolated mean sex-specific YPLL/patient was determined for the year 2001. The product of this mean and the estimated sex-specific lung cancer incidence for the year 2001 yielded the projected statewide YPLL from lung can-

cer in the year 2001. Gains in lung cancer therapy for the year 2001 can be subsequently quantified in terms of "regained" YPLL and compared to other cancer YPLL.

The described model projects 2,117 lung cancer deaths in Wisconsin in 2001 resulting in 24,790 "years of potential life lost." Lung cancer will continue to be Wisconsin's major cause of cancer mortality. Numerically small improvements in lung cancer cure or palliation will have profound effects on "regained" YPLL. As shown in Table 5, a 10% decrease in lung cancer mortality will "regain" 2,479 years. An improvement in 6-month survival in lung cancer will result in 1,060 years regained. A 10% reduction in lung cancer mortality plus a 12-month improvement in survival because of better palliation will regain more years (3,596) than the elimination of cervical and uterine mortality combined (2,693) and will exceed a 50% mortality reduction in leukemia, lymphoma, pancreas, or prostate cancer (1988 figures).[12]

Obviously, these statewide benefits can only be realized if all Wisconsin lung cancer patients have equal access to appropriate therapy.

Curative therapy for lung cancer represents an important therapeutic challenge. Strategies to enhance cure include early diagnosis, improved delivery of radiotherapy, identification of more effective systemic therapy and appropriate combinations of therapies.

In summary, lung cancer will continue to be the major cause of cancer mortality in Wisconsin in the year 2001, responsible for nearly 25,000 years of potential life lost. Despite historically poor cure rates from treatment, enormous clinical gains can be attained from improved therapy of lung cancer. For those future 2,000 or more Wisconsin residents diagnosed yearly with advanced lung cancer, improved therapy remains their primary hope for survival and represents a major challenge for Wisconsin physicians.

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Quit smoking.

American Heart Association

Student writing contest winner

The effect of alcohol consumption on body weight among Wisconsin adults

Kurt Hansen, MD, and Patrick L. Remington, MD, Madison

It is a common perception that alcohol use increases body weight. In fact, people are often advised to reduce their drinking if they wish to lose weight. To assess the relationship between alcohol use and body weight, we analyzed data from 5,496 Wisconsin men and women. We compared weights of drinkers and non-drinkers and adjusted for potential confounders. For women, there was a strong inverse relationship between drinking and weight. Women who drank any alcohol weighed an average of 2.6 kg (5.6 lbs) less than women who did not drink ($p<.0001$). This association was found for all types of alcoholic beverages. No difference in weight was found overall between drinking and non-drinking men, although men who drank wine weighed significantly less (1.8 kg, $p<.05$) than non-drinkers. These results, combined with other recent studies, suggest that alcohol use does not lead to increased weight among Wisconsin adults, and may be associated with lower weight among women. *Wis Med J.* 1992;91(7):348-350.

Not only has the adult population of Wisconsin been ranked as being the most obese in the country,[1] but the state also has the highest per capita sale of alcoholic beverages.[2] It is commonly perceived that drinking increases body weight. Previous studies, however, have shown an inconsistent association of alcohol use and body weight.[3] The general pattern has been that drinking is associated with increased weight in men and decreased weight in women. Therefore, we considered the question of whether alcohol use is associated with increased weight among Wisconsin adults.

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Methods

We analyzed data from the annual Wisconsin Behavioral Risk Factor Surveys (BRFS) from 1986 to 1990. The BRFS is a cross-sectional, random-digit telephone survey of the health practices of adults and is designed to represent the state's general population. It is carried out in nearly every state, including Wisconsin, in cooperation with the Centers for Disease Control. Participants report many characteristics including weight and alcohol use. There were 6,417 respondents, with slightly more women than men. The BRFS is described in detail elsewhere.[4]

We excluded non-whites from the study because their small number (315) did not provide enough information to do analysis by other individual races. We also excluded 606 individuals for which information about other variables was incomplete.

The primary outcome variable was weight to the nearest pound as reported by the participants. A second analysis using body mass index (weight/height^2) provided the same results.

Drinkers were defined as anyone reporting alcohol consumption during the past month.

We performed analysis of covariance using the generalized linear models procedure of SAS-PC. The analysis adjusted for predictors of weight other than alcohol consumption. These covariates were height, age, level of physical activity, smoking status, and income. Dietary information was not available as part of the BRFS. The model included height, age, and age-squared as continuous variables. Physical activity was categorized at four levels, income at seven levels, and smoking as current smoker or non-smoker. The similar characteristics of never smokers and former smokers allowed them to be grouped together.

Analysis of subgroups included classifying drinkers by both number of drinks per month and by type of alcohol consumed: beer, wine, or liquor. Many drinkers used more than one type of beverage and were, therefore, included in more than one subgroup. Comparisons of individual subgroups were done with non-drinkers as the referent group. Finally, we examined the relationship of drinking and smoking on weight, using non-drinkers and non-smokers as the referent group.

Results

The Table summarizes baseline characteristics that previous research had associated with both alcohol use and body weight.[5-7] Compared with non-drinkers, drinkers were younger, taller, had higher incomes, were more physically active, and were more likely to smoke.

Adjustment for these covariates did not change the relative weight differences between drinkers and non-drinkers. Women in Wisconsin who drank weighed an average of 2.6 kg less than non-drinkers ($p<.0001$). The decreased weight among women was observed irre-

Summary of baseline characteristics of drinkers and nondrinkers among white men and women in Wisconsin, Behavioral Risk Factor Surveys, 1986-1990.

	Women (n=2823)		Men (n=2673)	
	Non-drinkers (n=963) 34.1%	Drinkers (n=1860) 65.9%	Non-drinkers (n=544) 20.4%	Drinkers (n=2129) 79.6%
Mean weight (kg)	67.4 (66.5, 68.3)*	64.8 (64.2, 65.4)	83.0 (81.6, 84.4)	82.5 (82.0, 83.0)
Mean height (meters)	1.625 (1.621, 1.629)	1.645 (1.642, 1.648)	1.780 (1.774, 1.786)	1.790 (1.787, 1.793)
Mean age (years)	53 (51.8, 54.2)	42 (41.2, 42.8)	48 (46.5, 49.5)	41 (40.3, 41.7)
Income < $15,000 (%)	48% (45, 51)	29% (27, 31)	33% (29, 37)	20% (18, 22)
Current smokers (%)	19% (17, 21)	28% (26, 30)	25% (21, 29)	29% (27, 31)
Regular physical activity (%)	41% (38, 44)	49% (47, 51)	39% (35, 43)	48% (46, 50)

*95% confidence interval.

spective of the type of beverage(s) used (Figure). There was not a significant weight difference for men between drinkers and non-drinkers (0.3 kg). Men who drank wine, however, did weigh significantly less (1.8 kg) than non-drinkers.

The effect of quantity of alcohol consumed is shown in the Figure. There was a trend among women toward decreased weight with increasing alcohol consumption. There was no apparent dose-response relationship for men. The results were similar when quantities of each beverage type were considered individually (not shown).

The effect of drinking on weight was independent of all the covariates, including smoking. We found the average weight of current smokers was less (2.7 kg for women and 2.2 kg for men) than non-smokers (see Figure). Because the effects were independent, women who smoked and drank weighed an average of 5.3 kg less than women who neither smoked nor drank.

Discussion

It appears that women in Wisconsin who drink weigh less than those who do not, while among men there is no weight difference between drinkers and non-drinkers. This result is contrary to conventional wisdom but consistent with previous studies.

The relationship between alcohol use, diet, and body weight is complex. Alcohol not only provides calories to the diet, but may also change eating habits and affect the absorption and use of other nourishment. Clinical isocaloric studies have found that alcohol was less efficiently metabolized when substituted for other food. Other clinical experiments have demonstrated weight loss on prescribed alcohol regimens despite attempts to maintain constant body weight.[3]

The effects of smoking on body weight have been well described.[6] We found that women who smoked and drank weighed an average of 5.3 kg (11.7 pounds) less than women who neither smoked nor drank. Given society's preoccupation with body weight, this relationship may explain, in part, the continuing high rates of smoking among women, especially younger women.

Although it appears plausible that the effect of alcohol is to decrease body weight, our study does not prove a causal relationship. We adjusted our analysis for several potential confounders, but it may be that people who drink differ from non-drinkers in ways that were not considered, such as diet. The fact that even low levels of alcohol use were associated with decreased weight in women, and that the effect differs for men and women, suggests that other factors may be responsible for our findings.

Our study has the potential for the selection bias inherent in any analysis of survey data. We used self-reported weight and alcohol consumption rather than actual measurements and diaries. Previous studies have shown, however, that there is a high correlation between self-reported values and actual weight and alcohol use.[8] Self-reported information would bias our results only if there were differences in the way drinkers and non-drinkers responded. Similarly, any bias introduced by the exclusion of individuals who provided incomplete information would exist only if drinkers and non-drinkers failed to respond in a differential way.

Health recommendations concerning alcohol use need to consider all its potential health effects. Evidence continues to accumulate regarding the possible benefits associated with moderate consumption. Recent studies have shown a decreased risk of heart disease with moderate alcohol use.[9] This contrasts, however, with the well-known harmful effects of heavier alcohol use including alcoholism, and the increased risk of injuries, liver cirrhosis, and esophageal cancer.[10]

In conclusion, our results, combined with other recent studies, suggest that alcohol use does not lead to increased weight among Wisconsin adults, and may be associated with lower weight among women. Therefore, we recommend that when advising patients about weight loss,

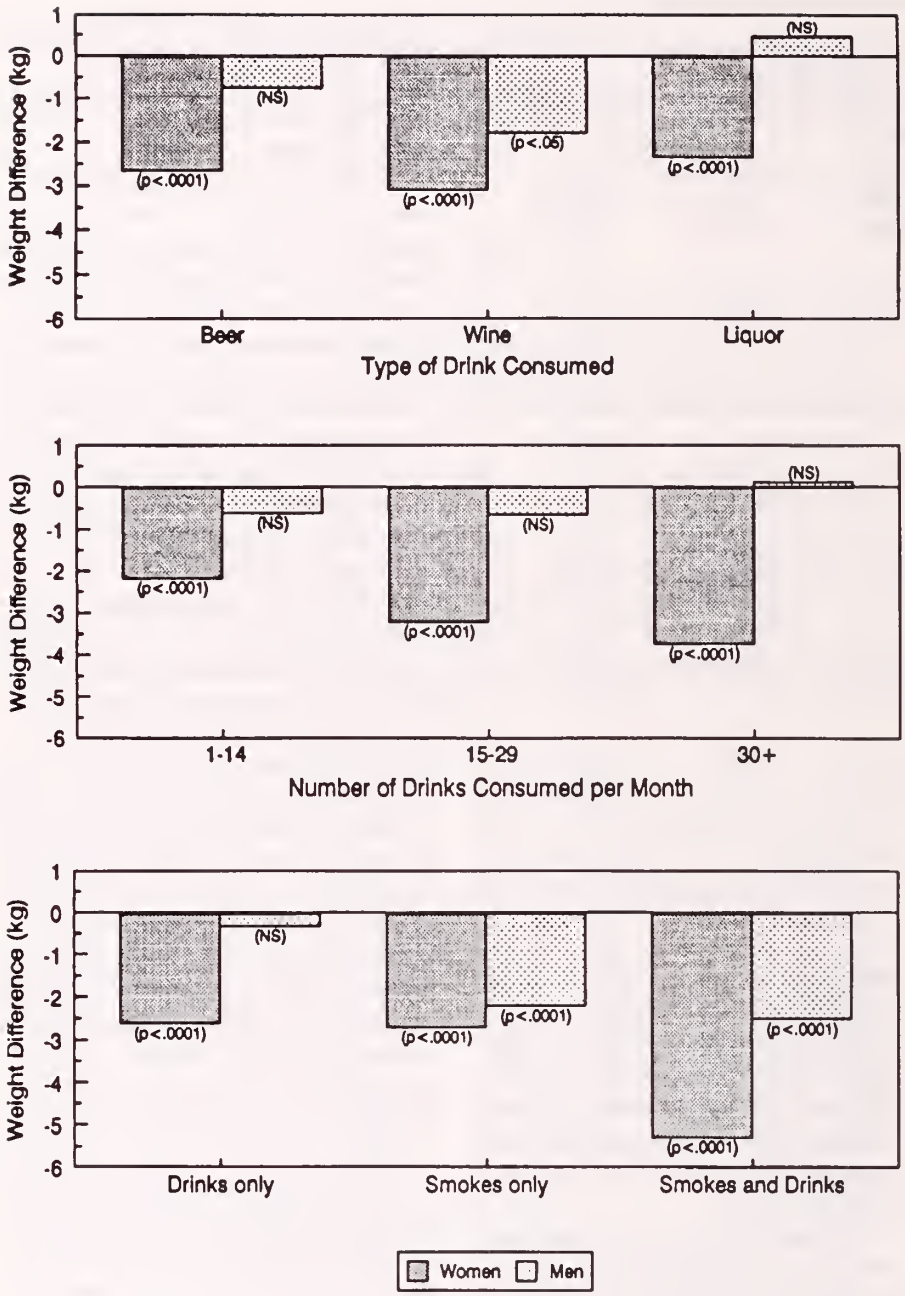

Fig. — Mean weight differences between non-drinkers and drinkers by type of alcohol consumed, number of drinks consumed per month, and smoking status. Non-drinkers are the referent group. Adjusted for height, age, income, physical activity level, and current smoking status.

physicians should stress exercise and diet rather than reducing alcohol intake.

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Graduate nursing student writing contest winner

Adolescent suicide: an analysis using Erikson's developmental framework

Janet M. Zimmerman, RN, Madison

THE TOPIC OF ADOLESCENT SUICIDE has been brought to the public's attention because of the alarming increase of suicides in the 15-to 24-year-old age group within the past 25 years. Suicide is now the second leading cause of death among adolescents (Centers for Disease Control, 1985), and the assessment of suicidal tendencies among youth is the most common emergency encountered by child and adolescent psychiatrists. Studies have indicated that between 6.7% and 12% of children and adolescents have some form of serious suicidal ideation.[1,2] Increased awareness about the rising rates of teenage suicide has stimulated the formation of several major policy groups to respond to this public health crisis among our nation's youth. The work of these groups has resulted in a general consensus that the study of youth suicide demands a multidisciplinary approach to its etiology, treatment, and prevention.

The purpose of this paper is to explore the dramatic rise in adolescent suicide and to formulate preventive strategies using Erik Erikson's normative adolescent theory of identity v identity diffusion,[3] which serves as a framework for understanding the integration of youth into society. The major demographic and psychosocial factors surrounding suicide in adolescence are described, and followed by a discussion of how Erikson's phase of identity v identity diffusion can provide an understanding of the increased rate of adolescent suicide. Finally, clinical implications for prevention intervention in suicide related situations are discussed.

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Demographics

As noted previously, suicide is the second leading cause of death among adolescents 15 to 19 years old. In addition, the rate of suicide in this age group has tripled in the past 3 decades, from 2.6 to 8.5 per 100,000 (Centers for Disease Control, 1985). Although some of the increase has been attributed to the willingness of persons reporting the cause of death to report suicide, there is no question that there has been a true increase in the youth suicide rate.[4]

The reasons for this increase remain unclear, but several hypotheses have been generated to explain the increased rate of youth suicide. For example, several researchers have suggested a cohort effect that has rendered the post World War II generation of youth more vulnerable to depression and, consequently, to suicide.[5] The relationship between suicide rates and population changes among adolescents has also been examined. Specifically, authors have described significant positive correlations of adolescent suicide rates, with changes in the size of the adolescent population and changes in the proportion of adolescents in the population of the United States.[6,7] The increase in suicide rate has also been linked to a parallel increase in alcohol abuse and greater availability of firearms.[4] Publicity about suicide has also been hypothesized to have added to the increased rate among youth,[8] as have the increased divorce rate, increased family mobility, and a decrease in religious affiliation.[9] Some authors have suggested that the competition for scarce resources that is associated with large birth cohorts has contributed to the increased rate of suicide among youth born after World War II.[6]

There are gender differences in youth suicide. Boys have the highest suicide rate in all young age groups (Centers for Disease Control, 1985). Boys complete suicide more often, although there are more attempts among girls.[10,11] An explanation for this difference is that boys choose more violent means of suicide, with the use of firearms being the most frequently used, while girls often use less lethal methods.[12]

A second demographic variable is ethnicity. More whites than non-whites commit suicide. It is among white males that the greatest increase in the suicide rate has been observed over the past decade.[4] While more whites than blacks commit suicide, the rate among the American Indian population exceeds either the white or black suicide rates. Although the suicide rate varies by tribe, higher rates have been observed among youth whose tribes have undergone more cultural assimilation.[13]

In contrast to the high suicide rate in industrialized countries, such as the United States and Canada, third-world countries, such as Mexico, report remarkably low rates (World Health Organization, 1988) The reasons for the discrepancy in suicide rates between third-world countries and industrial countries are unclear. Possible explanations include lack of accurate reporting and the lack of norms, both of which can occur in large areas of urbanization.[9]

A fourth demographic factor is religion. The role that religion plays in the demographics of suicide is not clear. Few studies have been conducted and those that have lack an in-depth study of the relationship between suicide and actual church attendance in contrast to a merely

superficial association with a religion (R. Enright, personal communication, April 12, 1991). Suicide rates vary by religious affiliations, being generally higher among Protestants than among Catholics and Jews.[14] The current increase in adolescent suicide rate in the United States coincides with a period of decreasing church membership; however, the relationship of suicide in the young to religious beliefs and affiliation has not been carefully studied.

In addition to these major demographic variables associated with suicide, there also are major precipitating psychological factors. The most salient of these is the presence of psychological depression.[11,1] The majority of experts agree this mood disorder appears to be the best predictor of a suicide act, but Hawton (1982), in a carefully controlled study, found depression was evident in only a minority of cases, while the presence of broken homes was evident in the majority.

A second isolated, but potentially important factor, was described by Tischler.[15] He reported on two women with documented diagnoses of mental illness who also experienced an elective abortion. On the potential anniversary of the aborted child's birth, each made a significant movement toward a suicide attempt. These case studies may alert others to the possibility of suicide ideation for those who have a history of inadequate coping.

A third psychological factor that may contribute to suicide is the presence of family conflict. Although general family disharmony can be predictive of many other outcomes as well, it is often present in the families of adolescent who have committed suicide.[11,16] Suicidal children and adolescents rate their family environments as less cohesive and more conflicted than do psychiatric controls.[17] In addition, the relationship between suicidal youth and their parents is characterized by greater hostility and enmity.[11] Not

Erikson's seven part conflicts of the identity crisis (along the horizontal)

VIII								INTEGRITY versus DESPAIR
VII							GENERATIVITY versus STAGNATION	
VI						INTIMACY versus ISOLATION		
V	Temporal Perspective versus Time Confusion	Self Certainty versus Self-Consciousness	Role Experimentation versus Role Fixation	Apprenticeship versus Work Paralysis	IDENTITY versus IDENTITY CONFUSION	Sexual Polarization versus Bisexual Confusion	Leader- and Followership versus Authority Confusion	Ideological Commitment versus Confusion of Values
IV				INDUSTRY versus INFERIORITY	Taxk Identification versus Sense of Futility			
III			INITIATIVE versus GUILT		Anticipation of Roles versus Role Inhibition			
II		AUTONOMY versus SHAME, DOUBT			Will to Be Onself versus Self-Doubt			
I	TRUST versus MISTRUST				Mutual Recognition versus Autistic Isolation			
	1	2	3	4	5	6	7	8

Erikson's Epigenetic Chart (From Erik Erikson, Identity: Youth and Crisis, New York: Norton, 1968. Copyright 1968 by WW Norton & Company, Inc.

only is current discord a risk factor for suicidal behavior, but those attempting suicide are more likely than psychiatric or medical controls to have experienced the loss of, or separation from, a parent.[10]

The final psychological issue is suicide contagion, which is the process by which one suicide facilitates the occurrence of a subsequent suicide. Contagion assumes either direct or indirect awareness of the prior suicide. Recent studies by Gould[8] have indicated that suicide clusters occur predominantly among teenagers and young adults. Both imitation and identification have been hypothesized to increase the likelihood of cluster suicides. It is possible that adolescents may not relate to the finality of the suicide act and may be relating to peer-related behaviors.

Durkheim's model

To find an explanation for why adolescent suicide remains a large social problem despite extensive research done within the past 15 years, it may help to examine this social problem in the context of a theory of suicide. Durkheim was the first sociologist to produce a systematic and comprehensive theory of suicide, which he reported in his book *Le Suicide*.[18] His approach was based on a distinction he believed existed between the explanation of individual cases of suicide and the explanation of a society's suicide rate. The apparent fluctuations in suicide rates are a "social fact" that can be demonstrated sociologically.

According to Durkheim, differences between suicide rates are a function of the extent to which individuals are constrained by the moral forces of unified social life. These forces work in two ways. First, they integrate individuals by joining them to the values and norms of social groups. Second, they control individual's desires by defining specific goals and the means of attaining them.[18] Durkheim proposed four kinds of suicide, each of them suggesting the strengths or weakness of the individual relationship or ties to society:[19]

- altruistic suicide, or those that are required by society (eg, hari-kari);
- anomic suicide, or those that occur when there is a rapid or sudden change for the worse in an individual's life (eg, untimely loss of a loved one);
- fatalistic suicide, or that which occurs in a rigid or over-protective society (eg, slaves, caste systems); and
- egoistic suicide, or that which occurs when an individual is not well integrated into the society and lacks ties with the community.

Egoistic suicide may relate most closely to the underlying reasons adolescent suicide is a growing problem, because the shifting demographics of adolescents may predispose them to isolation and lack of integration into society. Adolescents today are more likely to be from single-parent families with smaller and more remote extended families. In a Bureau of the Census Report (1990) nearly one quarter of all children under the age of 18 lived in single parent homes, and between the years of 1979 and 1984 there was an increase of 124% in the number of single-parent families.[20] In addition, families are less likely to remain in a single location, thereby limiting the time available for children to make friends and develop social bonds.[9]

Perhaps we can begin to understand adolescent egoistic suicide better by exploring Erik Erikson's psychoanalytic theory as it pertains to normal adolescent development, the sense of identity v the sense of identity confusion. The implications of Erikson's theory can offer insight into understanding this important societal problem and generate measures that will maximize integration of our youth into society.

Erikson's concept

Erik Erikson's theory originated from Freud's analytic theory. Although its basis lies in psychoanalytic thought, Erikson expanded in three specific areas. The first involves an emphasis on the ego, rather than on the id. He assumed that the function of the ego goes beyond guiding the development of sexuality and is linked with the continuity of experience in the environment. Although he accepted most of Freud's theory, he focused on the development of the healthy personality in contract to Freud's emphasis on pathology (Thomas, 1985).

Erikson also presented a new framework for describing relationships within a person's environment. He emphasized the process of becoming socialized into a culture by passage through a series of eight innately determined psychosocial stages. These relationships included the relationship of the individual to parents and family, to a wider social setting, and to the family's historical cultural heritage. To quote Erikson, "We cannot separate personal growth and communal change, nor can we separate ... identity crisis in individual life and contemporary crisis in historical development, because the two help to define each other and are truly relative to each other."[3]

The third major difference between Erikson and Freud was Erikson's optimistic premise that every personal and social crisis furnishes components that are conducive to growth.[21] Erikson believed that individuals encounter ongoing developmental crises through life, and that these crises are seen as having the potential to promote growth. This view differed from Freud's, which perceived a problem in development as creating a permanent psychological handicap.

In addition, Erikson views the individual as creative, adaptive, and capable of constructing both good and bad in life through interplay with the surrounding culture and society. Erikson also sees individual behavior at each stage as evolving through a constant interplay between two opposite or conflicting personality characteristics, causing struggles that continue to be evident in all developmental crises throughout life.

Erikson's concept of development is a continually changing process based on universal experiences of biological, psychological, and social events. He has divided personality development into five phases. Erikson believes that an individual does not have a static personality, but is always redeveloping one. Each phase is connected to the previous one and plays a part in an person's total and ongoing development. According to Erikson, life follows an epigenetic sequence and, as the developmental sequence unfolds, the person is faced with a central problem to master in each phase. Thus, development

is a continuous process that works out future solutions on the basis of past developmental phases.

Identity v confusion

Erikson has described eight epigenetic developmental stages, but paid considerably more attention to the last phase of childhood, the sense of identity v identity confusion. Erikson states that it is no coincidence that he spent more effort describing identity and its struggles than he spent on any other phase, for he emigrated to this country after marrying an American and thus identity became an important aspect of his life.

Erikson visualized his stages on a grid having both a vertical axis ending in an individual psychosocial solution, and an horizontal axis creating a personally and socially satisfactory solution to the problem. The grid attempts to clarify the interactions among various aspects of development (see Table).

An important aspect of identity development is the individual's inability to separate personal growth from community change. "Identity is linked to historical development because the two help to define each other and are truly relative to each other."[3] Therefore, it can be said that identity issues are not only developmental, but are also social ones.

Erikson's initial conceptualization of ego identity was very narrow, but in his book *Identity, Youth and Crisis*, he expanded it into a three-pronged construct. First, he described identity as a conscious sense of individual uniqueness. Second, it is an unconscious striving for continuity of experience, in which one tries to be the same person one was yesterday; and third, it is a solidarity with the group's ideals, an awareness of a connectedness among us all. Although identity is constantly changing, the individual tries to keep it the same. This struggle emerges for the first time in the normative crisis of adolescence. The identifications that take place are solidly complete when the childhood identifications are replaced by a new adult identification.

Before this new identification occurs, there is a period of socially accepted delay of adulthood that acts as a psychological safety device. Erikson has labeled this period a psychosocial moratorium. It is a time constructed by society for adolescents to figure out who they are. In our society, a deliberate social structure allows for the moratorium. For example, high school, college, technical school, and travel are all structures that allow delay into adulthood, provide experimentation with new roles, and offer opportunities to develop a healthy identity. Social structures thus allow youth a time of selective permissiveness to experiment with different forms of identity before absolute decisions are made.[3]

Erikson has described seven different dimensions that may contribute to the identity development of the adolescent. The adolescent may experience conflicting aspects of one dimension alone or in combination with others.

The seven dimensions are as follows:

Time perspective v time diffusion. A persons' concept of time is essential to identity. If the adolescent's time perspective is a problem the youth may demand immediate action or may become immobilized completely, hoping that time will stand still and that disappointment will never occur. Only when youths see their lives in a specific perspective does a sense of time lead to a sense of full identity.

Self-certainty v self-consciousness. A youths' self-certainty involves a struggle between identity consciousness and apathy. In this dimension the person attains a clear view of who he or she is becoming. As this independence grows, feelings of doubt and confusion recede.

Role experimentation v role fixation. The person in this dimension consciously and deliberately attempts to act out a new role. Experimentation with opposites, especially those frowned on by adults, becomes the core of the adolescent's experimentation. Ultimately, identity depends on successful experimentation with a wide range of roles.

Apprenticeship v work paralysis. While this dimension may involve completing a task, it may also involve the struggle of even beginning one. Persistency and integration are needed for forming an occupational identity and for making future plans.

Sexual polarization v bisexual confusion. The period of adolescence provides opportunities for continued experimentation with gender roles. This contributes to a complete sense of identity and helps in achieving intimacy.

Leadership polarization v authority diffusion. This dimension involves the struggle for a realistic view of authority and a readiness to be in authority, and is closely linked with the ability to master previous phases.

Ideological polarization v diffusion of ideals. This dimension is the central point of the identity search, which relates to developing a basic philosophy of life, to commit to a certain world view, and to realize that not everything in the wold is open to everyone. The adolescent needs to select a basic philosophy, ideology, or religion that will provide the foundation for trust in his or her life.

During adolescence, there is the opportunity to grow and develop in the dimensions as outlined by Erikson using the time provided in the society-sanctioned moratorium. If, during the moratorium, this developmental stage is not mastered, it may be because the adolescent has committed to adult society before he or she is ready. Such adolescents may then experience feelings of failure at being unable to resolve identity crises, and be at a loss as to what kind of people they are, and feeling that they do not know what to be or who they are in the eyes of themselves or others.

Thus, Erikson's conceptualization of self-identity is important to the process of finding out who we are, how we are different from others, and how to be the same person we were yesterday. It is through this process that adolescents choose life commitments and develop a philosophy of life.

Based on Erikson's conceptualizations, it is possible to formulate several hypotheses as to why there has been a

dramatic increase in adolescent suicide within the past 25 years. For the sake of this discussion each hypothesis is examined separately, although in reality they are probably related.

On the basis of a number of sociological studies both within the United States and elsewhere in western culture,[9] established that there is a relationship between the rate of suicide and the degree of social cohesion found in a particular society. It is probable that contemporary American society is becoming less socially cohesive. The high divorce rate, increasing number of single-parent families, dissolution of the extended family with fewer grandparents living in the home, and decline of religious involvement can all be taken as evidence of decreased "cohesion" in current American society.[9] In the face of these changes, adolescents may be less able to achieve the feeling of connectedness necessary to a sense of identity and may subsequently withdraw.

Changes in our society have made it difficult for adolescents to work out the conflicts they experience. For example, one of the dimensions within the identity achievement crisis is role experimentation v role fixation. The accepted moratorium of youth in our society has allowed adolescents to delay role choice and become unfocused in role expectations. Years ago, a greater proportion of children would see their fathers working on farms or owning a business, and would have had the experience of relating to a role. It is more common today to have parents leave home for work, with no concrete definition or product tied to the work role.[22] In addition, there appears to be more freedom in our society, with fewer limits, fewer guidelines, and less role modeling for resolving conflicts.

One could argue against a sociological cause for adolescent suicide and offer a case for economic or intrapsychic causes. Either of the latter two factors could contribute to suicide, but either cause alone appears too simplistic and narrow to account for the significant increase in adolescent suicide in the past 25 years. A review of the current literature suggests that suicide among the young is a societal problem that needs cooperation from parents, adolescents, schools, governments, and health care providers to propose solutions.

Since a lack of connectedness, confusion about role choice, or an inability to develop a philosophy of life may contribute to an increase in suicide, preventative actions must provide an avenue to promote youth's successful integration into society. As described earlier, Erikson's theory does not separate the adolescent from the parents' social setting or cultural heritage, but takes into account the interplay among these relationships.

Clinical implications

A clinician in school or clinic is in a position to both assess for and design interventions to prevent adolescent suicide. For example, a nurse working in a school or clinic could offer a depression screening tool to all students at a specific point in their high school career. As stated earlier, depression has been described as a major precipitating factor associated with adolescent suicide.[11,1] By providing this assessment, the health care professional may increase his or her chances of detecting students with depression, thereby possibly circumventing a problem before it occurs.

Specific understanding of adolescent development is essential in designing counseling to help prevent possible suicide. For example, the health care professional could plan and participate in support groups for specific populations in the school or community that may not feel connected. An example of a group might be Southeast Asian students, school age parents, or students who have a parent with a life-threatening disease. Participation in support groups can offer students an opportunity to see others like themselves and, in turn, provide experiences for socialization with peers that is of paramount importance to adolescents. These groups may help students develop in Erikson's dimensions of self-certainty and role experimentation. An offshoot of participation may also offer opportunities for leadership and a forum to question ideals.

The health care professional has a responsibility to promote the mental health of adolescents in clinic or schools by providing anticipatory guidance to parents as well as to the adolescent. Research has provided substantial evidence that familial discord and disruption serve as a key antecedent to suicidal behavior.[16] Health care professionals play a key role in helping families develop positive communication styles and in providing information to parents that facilitates understanding of development.

To promote identity formation, it is also important to provide quality interpersonal contact. The clinician in a clinic or school has the opportunity to interact with individuals over time and, subsequently, to build trusting relationships. In the book *Turning Points*,[23] the Carnegie Institute delineated actions that can optimize the growth of our teenagers and pointed out the importance of getting to know the youth with which one works. The institute suggests that, in schools, each student should be known well by at least one adult. The importance of providing social contact is confirmed by Reece,[23] who described chronic social isolation as one of the most striking features differentiating school-age victims from their peers, and by Seidan,[25] who found social isolation to be a major prodromal sign in college students who attempt suicide, persons whom he described as "terribly shy, virtually friendless individuals, alienated from all but the most minimal social interactions."[26] Building a trusting relationship could lead to a willingness to discuss personal problems that can then be alleviated or referred to a counselor. The trust engendered might also encourage students to identify peers who may be potentially suicidal but may not seek help on their own.

Adolescents can also benefit from opportunities to try out different roles and experience a variety of situations, for example, participating in community service programs led by a concerned role model. These experiences should provide the opportunity to share in leadership roles, become a member of a group, take responsibility, and, probably most important, build on developing values, beliefs, and a philosophy of life, key components in forming a sense of identity.

One of the major problems facing planners of suicide prevention programs for adolescents is the lack of substantial and convincing data about the efficacy of existing programs in the adult population. In the past, little systematic research has been undertaken to compare and test different interventions.[27] Evaluation studies of suicide prevention centers have generally found that they have not had much of an effect on preventing suicide.

More extensive and refined evaluation of suicide prevention programs is needed to shed light on their efficacy and on what components of the interventions are most helpful. It may be beneficial to focus on identified high-risk groups to enhance the productivity of prevention programs.[28] Although it is clear that current approaches to suicide prevention have not demonstrated their effectiveness, knowledge of social, environmental, and psychological variables associated with suicide point out some general considerations.

At the macro-social level of prevention, any social measures that either decrease social disorganization and social isolation or increase social integration and the availability of social supports can be expected to have some effect on the incidence of suicidal behavior at the population level.[26] In addition to contacts among health care professionals and adolescents, governmental bodies on all levels should become active participants in decreasing this societal problem. They have a responsibility to send a message to the people in this country that says the government values the tremendous potential of human resources that exists in all families, regardless of age or earning ability. For example, within each geographic location surrounding neighborhood schools, a community school center could be developed where parents, families, and elderly could gather, communicate, and support one another. Both organized and less structured programs could be offered, such as parenting classes, dances, open gyms, and youth community participation.

At the micro-social level, knowledge of the importance of early family influences in the predisposition to suicidal vulnerability should lead health care professionals to encourage any preventive and intervention measures that support and sustain the family unit and decrease the extent to which parents are unavailable to children, discontinuities in parental care, and child neglect and abuse.[26] The causes of teenage suicide do not begin in adolescence. Families hold the primary responsibility for the emotional and physical welfare of their children. It is families that possess the potential to develop a set of values that can guide children in developing a philosophy of life. Finally, schools need to continue to educate students about individual and cultural differences, circumventing feelings of stigmatization and isolation, thus allowing students to develop in all seven dimensions of Erikson's identity v identity confusion.

Since the causes of suicide are not completely known and the variables are complex, it may be best to focus on the adolescent's sense of connection with others, drawing on Durkheim's[14] model of suicide as a framework. Durkheim viewed the risk of egoistic suicide as increased in individuals lacking ties with the community and not well integrated into society. By fostering a sense of community, clinicians may also help indirectly to prevent psychiatric illness such as depression.

Clinicians working with the adolescent population can play a unique role in helping youth achieve a sense of identity. In addition, researchers must continue their efforts to identify the causes and clues to suicide. Reasons for an increasing rate of adolescent suicide are not well defined, nor have interventions been evaluated, although, recent studies have defined groups at potentially high risk. An understanding of Erikson's developmental framework provides a basis for identifying potential risks specific to adolescence and designing preventative measures.

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William J. Listwan, MD, an internist from West Bend, graduated from Marquette University in 1964, receiving a bachelor's degree in philosophy. He went on to earn his medical degree from the Medical College of Wisconsin and interned at Wayne County General Hospital in Detroit. Board certified, he completed a residency in internal medicine at the Medical College of Wisconsin in 1974. He was chief medical resident in 1973-74. Dr. Listwan has been a member of the SMS Board of Directors since 1984, representing District 1 (southeast Wisconsin). He has served as a member of the Physicians Alliance Commission and chair of the Medical Liability Committee. Dr. Listwan currently serves on the SMS Medical Liability Committee and the Task Force on Alternatives to Tort Reform. He also sits on the board of directors of the Physicians Insurance Company of Wisconsin. Dr. Listwan was elected president of the Washington County Medical Society and served from 1976 to 1977. He also served as president of the Wisconsin Society of Internal Medicine from 1989 to 1990. Dr. Listwan is currently a member of the WISPAC Board. A member of the medical staff at St. Joseph's Community Hospital of West Bend since 1974, Dr. Listwan served as president of the hospital's medical staff from 1986-1988. He was named medical director of respiratory therapy at St. Joseph's Community Hospital in 1979, and continues to serve in that capacity. Dr. Listwan is in practice with the General Clinic in West Bend, a multispecialty clinic with 22 physicians, and presently serves as clinic president. In addition to his practice, Dr. Listwan is an assistant clinical professor of medicine at the Medical College of Wisconsin. He serves as medical director for several West Bend industries. A leader in his community as well as his profession, the West Bend physician is a former parish school board member and school board president. He sings in his church choir and was a member of the advisory board for the Southeast Wisconsin Veterans Memorial Fund, helping to raise money for the Vietnam Memorial in Milwaukee.

Continued on next page

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Cyril M. (Kim) Hetsko, MD

Richard G. Roberts, MD, JD

Kenneth I. Gold, MD

Richard H. Ulmer, MD

Raymond C. Zastrow, MD

Continued from preceding page

Pauline M. Jackson, MD
La Crosse
President elect
(1992-1993)

Dr Jackson graduated from Stanford University Medical School and served her internship at Charles T. Miller Hospital in St Paul, Minn. Board certified in psychiatry, she completed her residency at the Cleveland Psychiatric Institute. Dr Jackson is a member of the SMS Board of Directors, and is chair of the Mental Health Committee and member of the Physicians Alliance Commission. She served as president of the La Crosse County Medical Society from 1984 to 1985, and as secretary of the Wisconsin Psychiatric Association (president in 1987 to 1989). Dr Jackson served on the board of directors of the Gundersen Clinic and as chief of staff at Lutheran Hospital in La Crosse.

Thomas L. Adams, CAE
Madison
Executive Vice President
(1992-1993)

Thomas L. Adams was named secretary-general manager of the SMS in 1987. Adams was director of the Washington, DC, office of the American Society of Anesthesiologists prior to joining the Society in 1986 as secretary-general manager designate. Adams served as assistant executive director and lead lobbyist for the North Carolina Medical Society from 1978 until 1983, when he joined the anesthesiology group. Adams graduated from Lenoir Rhyne College in Hickory, NC.

William P. Crowley, Jr, MD
Madison
Treasurer
(1992-1993)

Dr Crowley had served on the SMS Board of Directors from 1976 to 1985. He had served on the SMS Committee on Economic Medicine and is an assistant treasurer of SMS, serving from 1985 to the present. Dr Crowley has served on the Board of Directors and as president of SMS Services, Inc. from 1980 to 1989. He

graduated from the University of Wisconsin Medical School and served an internship at the Graduate Hospital of the University of Pennsylvania. His general internal medicine residency was served at the Mayo Clinic in Rochester.

Cyril M. (Kim) Hetsko, MD
Madison
Immediate Past President
(1992-1993)
Dr Hetsko graduated from the University of Rochester School of Medicine and Dentistry and completed his internship and residency and was chief resident at the University of Wisconsin Hospitals. He has been a member of the Dean Medical Center since 1975 and is a clinical associate professor of medicine at the University of Wisconsin, Madison. Dr Hetsko is active in the Wisconsin Society of Internal Medicine, serving as president from 1987 to 1988. He is chair of the SMS Task Force on AIDS. In addition, he was vice speaker of the SMS House of Delegates; a member of the Task Force on RBRVS, Strategic Planning Committee, and Task Force on Physician Discipline and Review; and served on the SMS Board of Directors for 9 years and was chair of its Finance Committee. He has been a member of the Wisconsin delegation to the AMA since 1983, serving as alternate delegate and current secretary. He is a past chair of the Department of Medicine at St Mary's Hospital Medical Center, Madison, and was a member of its Medical Staff Executive Committee. He is currently a member of the Infection Control and Pharmacy and Therapeutic committees, as well as a past member of its Institutional Review Board. He has received the Presidential Award from the Dane County Medical Society and the SMS Meritorious Service Award. Dr Hetsko is now a trustee of the American Society of Internal Medicine.

Richard G. Roberts, MD, JD
Madison
Speaker, House of Delegates
(1991-1993)
Dr Roberts graduated from George Washington University Medical School in Washington, DC. He is an associate pro-

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Robert F. Purtell, Jr, MD

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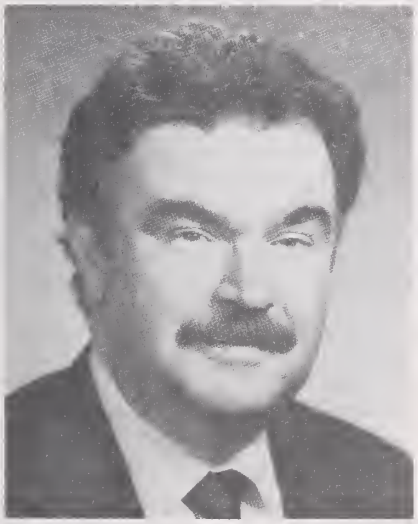

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Ayaz M. Samadani, MD

Continued from preceding page
fessor of family medicine at the University of Wisconsin, Madison. Dr Roberts is vice chair of the SMS Medical Liability Committee. He was first elected speaker of the House in 1987. He also serves on the American Academy of Family Physicians' Commission on Legislation and Government Affairs and chairs the Task Force on Clinic Policies for Patient Care. He is a past president of the Wisconsin Academy of Family Physicians. In addition, Dr Roberts serves as an SMS representative on the board of governors of the Patients Compensation Fund and the Wisconsin Health Care Liability Insurance Plan.

Kenneth I. Gold, MD
Beloit
Vice speaker, House of Delegates
(1992-1994)
Dr Gold, whose specialty is internal medicine, graduated from the State University of New York-Downstate. He completed a residency in internal medicine at University Hospital in Columbus, Ohio, and a fellowship in psychiatry and medicine at Strong Memorial Hospital, Rochester, NY. Dr Gold served on the SMS Commission on Continuing Medical Education for 9 years, and was chair for 3 years. He is currently chief of staff at Beloit Memorial Hospital, and has served as president of Rock County Medical Society, president of Wisconsin Society of Internal Medicine, and a secretary for the Wisconsin Chapter of American College of Physicians. He is an editorial associate of the Wisconsin Medical Journal.

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Continued on page 364

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School of Medicine at Loyola University in Chicago, he specializes in internal medicine and cardiovascular diseases. He completed a rotating internship and residency at the University of Chicago Hospital. He was a member of the House of Delegate's Nominating Committee from 1978 to 1980 and has served as an alternate delegate to the AMA since 1983. He is a past president of the Wood County Medical Society.

Raymond C. Zastrow, MD
Milwaukee
Vice chair, Board of Directors
Director, District 1
(1992-1995)
Dr Zastrow, who specializes in clinical pathology, graduated from Marquette University School of Medicine (now the Medical College of Wisconsin). He served on the SMS Physicians Alliance Commission from 1977 to 1989 and is a member of the WISPAC Board of Directors. He served as chair of the SMS bylaws committee, a member of the Finance Committee and was an alternate delegate to the AMA in 1983 to 1984. Dr Zastrow has also served on the SMS ad hoc committee on the Health Policy Agenda for the American People (HPA).

Robert F. Purtell, Jr, MD
Milwaukee
Director, District 1
(1992-1995)
A family physician, Dr Purtell graduated from Marquette University School of Medicine (now the Medical College of Wisconsin) in Milwaukee and served an internship at Misericordia Hospital. He completed a residency at St Joseph's Hospital, also in Milwaukee. Dr Purtell was a member of the SMS Physicians Alliance Commission from 1977 to 1989, having served as chair. He is also active in the American Academy of Family Physicians (AAFP) and serves as an SMS alternate delegate to the AMA. He is a member of the Wisconsin delegation to the AAFP, a past president of the Wisconsin Academy and a past president of the Marquette-Medical College of Wisconsin Medical Alumni Association.

Jay F. Schamberg, MD
Waukesha
Director, District 1
(1991-1993)
A pathologist, Dr Schamberg received his medical degree from Hahneman Medical College and served his internship at Chestnut Hill Hospital in Philadelphia. Dr Schamberg completed his residency at the Peter Bent Brigham Hospital in Boston and the University of Vermont Hospital in Burlington. He serves on the medical staffs of Community Memorial Hospital and West Allis Memorial Hospital. Dr Schamberg is president elect of the Wisconsin Society of Pathologists and a past president of Waukesha County Medical Society.

Marvin G. Parker, MD
Racine
Director, District 1
(1990-1993)
An hematologist, Dr Parker received his medical degree from the University of Missouri in St Louis, and served his residency and fellowship in internal medicine and hematology at the University of Missouri. Dr Parker began practice in Racine in 1966, and in 1986, joined SC Johnson Wax as corporate director of occupational and preventive medicine and in 1990 became vice president of Corporate Medical Affairs. He has chaired the SMS Health Planning Commission for five years and also chaired the SMS Task Force on Medical Manpower.

George R. Schneider, MD
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A specialist in internal medicine, Dr Schneider graduated from Marquette Univer-

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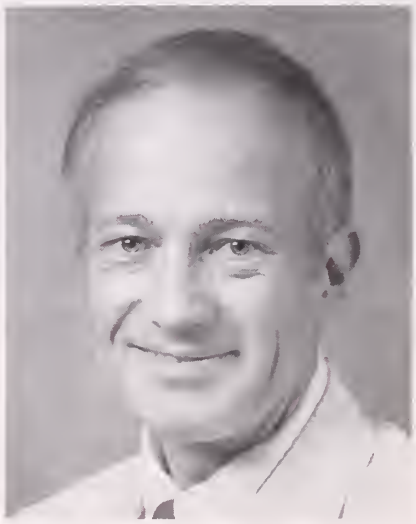
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sity School of Medicine (now the Medical College of Wisconsin) in Milwaukee and served an internship at the University of Missouri Medical Center in Columbia. He also completed a residency at the Medical College. Dr Schneider is a member of the American Society of Internal Medicine and the American College of Physicians.

Richard H. Strassburger, MD
Cudahy
Director, District 1
(1991-1994)
Dr Strassburger received his medical degree from St Louis University. A specialist in neurosurgery, he served an internship at Milwaukee County Hospital and residencies at Milwaukee County Hospital and the University of Minnesota. Dr Strassburger is also a director of the Medical Society of Milwaukee County.

Thomas A. Reminga, MD
Milwaukee
Director, District 1
(1992-1995)
Dr Reminga, whose specialty is emergency medicine, graduated from the University of Michigan Medical School and completed his residency at the University of Chicago. He was a member of the SMS Health Planning Commission, has served as an alternate delegate to the SMS and is currently a member of the Finance Committee. He has served as president of the Wisconsin American College of Emergency Physicians and as president of the Medical Society of Milwaukee County. He is the director of Emergency Health Services of Milwaukee County.

Marcia J.S. Richards, MD
Milwaukee
Director, District 1
(1990-1993)
Dr Richards received her medical degree from the University of Wisconsin Medical School in Madison and completed an internship and a residency at University Hospitals. A board-certified specialist in radiation oncology, she is currently director of radiation oncology at St Luke's Medical Center in Milwaukee and is a past president of the Medical Society of Milwaukee County. She has also served as secretary-treasurer of the organization and is a past president of the Wisconsin Society of Radiation Oncologists and secretary-treasurer of the Wisconsin Radiological Society. Dr Richards has been a delegate to the SMS since 1983. She is active in the Wisconsin Division of the American Cancer Society, having served as chair of its Breast Cancer Detection Awareness Project and as a member of its board of directors, and is currently chair of the Professional Education Committee.

John E. Ridley, III, MD
Milwaukee
Director, District 1
(1990-1993)
Dr Ridley, an ophthalmologist, graduated from the University of Indiana School of Medicine. His residency was completed at the Marquette School of Medicine. He is currently the assistant clinical instructor in ophthalmology at the Medical College of Wisconsin. Dr Ridley served as a captain in the US Air Force from 1961 to 1963. He is a member of the Milwaukee Ophthalmology Society and the American Academy of Ophthalmology.

Timothy G. McAvoy, MD
Waukesha
Director, District 1
(1990-1993)
Dr McAvoy graduated from New York Medical College. Specializing in internal medicine and emergency medicine, Dr McAvoy served his internship at Boston City Hospital. His residency was completed at Boston City Hospital and the University of Wisconsin Hospital and Clinics in Madison. He served as president of the Waukesha County Medical Society and has been a member of the Physicians Alliance Commission since 1987.

Continued on next page

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Charles E. Pechous Jr, MD
Kenosha
Director, District 1
(1990-1993)
Dr Pechous, a family practitioner and general surgeon, graduated from Loyola-Stritch School of Medicine. His internship and residency were completed at Cook County Hospital in Chicago. Currently, he is the medical director at the Modine Company in Racine. He is a member of the American College of Surgeons and the Wisconsin Chapter of the American College of Surgeons.

William L. Kopp, MD
Madison
Director, District 2
(1991-1994)
Dr Kopp was elected to the Board of Directors in 1989. Board certified in internal medicine and allergy and immunology, he received his medical degree from the University of Michigan and served an internship at St Luke's Hospital in Cleveland. He completed a residency and a fellowship at the University of Michigan. Dr Kopp is a fellow in the American Academy of Allergy and Immunology and the American College of Physicians. He is also a past president of the Dane County Medical Society.

Ayaz M. Samadani, MD
Beaver Dam
Director, District 2
(1991-1994)
A family physician, Dr Samadani received his medical degree in Pakistan. He served his internship at Henrotin Hospitals in Chicago. He spent 5 years of post graduate training in internal medicine and pediatrics in London. He is a fellow of the Royal Society of Tropical Medicine and Hygiene and certified in child health from the Royal College of Physicians and Surgeons of London. He has been in practice in Beaver Dam since 1971, and is chair of the pediatric department of Beaver Dam Community Hospital. He has served as secretary and president of Dodge County Medical Society and is president of the Wisconsin chapter of the Association of Pakistani Physicians of North America. He is a fellow of the American Academy of Family Physicians.

Sandra L. Osborn, MD
Madison
Director, District 2
(1991-1994)
Dr Osborn, whose specialty is pediatrics, graduated from the University of Wisconsin Medical School in Madison. She is a member of the WISPAC Board of Directors and co-chair of the SMS/WNA Committee. Dr Osborn served as president of the Dane County Medical Society from 1982 to 1983. She has also served as chair of the SMS Committee on Women Physicians, the House of Delegates Nominating Committee, the Credentials Committee and the Reference Committee on Scientific Affairs. Dr Osborn also served on the Ad Hoc Committee on Child Abuse and Neglect.

John D. Wegenke, MD
Madison
Director, District 2
(1992-1995)
Dr Wegenke, a urologist, graduated from the University of Wisconsin Medical School in Madison. He served an internship at San Joaquin General Hospital in Stockton, Calif, and internships in general surgery and urology at University Hospital and Clinics in Madison. He is an editorial associate for the Wisconsin Medical Journal, and has served the Dane County Medical Society in various offices, including president.

Jerry M. Ingalls, MD
Monroe
Director, District 2
(1992-1995)

Dr Ingalls, is the medical director of St. Clare Hospital/The Monroe Clinic and director of the Occupational Medicine department. He graduated from Duke University, Durham, North Carolina, completed his internship and residency at

William E. Raduege, MD

Robert J. Jaeger, MD

James L. Basiliere, MD

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Stephen D. Hathway, MD

Duke University and the University of Oklahoma. A past president of the Illinois State Medical Society (1975), he presently serves on the SMS Committee on Health Care Financing and Delivery and is chairman of the SMS Task Force on Parameters of Practice and Outcomes Management. Dr Ingalls also is an SMS representative on the 1992 Wisconsin Hospital Association and Wisconsin Manufacturers Association Task Force.

Andrew B. Crummy, Jr, MD
Madison
Director, District 2
(1992-1995)
Dr Crummy is a professor of radiology at the University of Wisconsin Hospital and Clinics. A native of New Jersey, Dr Crummy graduated from Boston University Medical School and served his residency at University Hospital and Clinics in Madison. He has been a member of the editorial board for the *Wisconsin Medical Journal* since 1985.

Jack M. Lockhart, MD
La Crosse
Director, District 3
(1992-1995)
A specialist in rheumatology, Dr Lockhart graduated from Harvard Medical School and served an internship at University Hospitals of Cleveland. He also completed fellowships at the University of Minnesota Medical School in Minneapolis. Dr Lockhart has served as a delegate to the SMS and as a member of the Nominating Committee. He also served on the SMS Physicians Alliance Commission for 9 years and is a member of the SMS Finance Committee and the Executive Committee of the La Crosse County Medical Society.

Mark H. Andrew, MD,
Viroqua
Director, District 3
(1992-1995)
Dr Andrew, a general surgeon, graduated from the University of Wisconsin Medical School, and served his internship and residency at Southwestern Michigan Area Health Education Center in Kalamazoo. He was elected chairman of the Young Physicians Section of SMS in 1991. He also is a member of the SMS Physicians Alliance Commission, the SMS Ad Hoc Membership Committee and is the current president of the Vernon County Medical Society.

William E. Raduege, MD
Woodruff
Director, District 4
(1992-1995)
William E. Raduege, MD has served as a board member since 1986. He has been board certified as a family practice physician since 1976 and has been practicing medicine in the Lakeland area of Minocqua-Woodruff since 1973. Dr Raduege is also a prior member of the Commission on Mediation and Peer Review from 1980-1989. Additionally, he is the current delegate to the State Medical Society from the Oneida-Vilas County chapter. Currently, Dr Raduege is an assistant clinical professor with the Medical College of Wisconsin and serves as a Preceptor with the University of Wisconsin Medical School.

Robert J. Jaeger, MD
Stevens Point
Director, District 4
(1991-1994)
Dr Jaeger is a specialist in obstetrics and gynecology. He attended the University of Wisconsin Medical School and served an internship and residency at Milwaukee County General Hospital. Dr Jaeger is an assistant clinical professor in the Department of Obstetrics and Gynecology at the Medical College of Wisconsin and serves on the board of directors of the University of Wisconsin Medical Alumni Association. He has served on the SMS Board of Directors since 1988 and is currently a member of the SMS Committee on Maternal and Child Health. Dr Jaeger is a member of the board of directors for the Portage County Medical Society as well as an alternate delegate. He is president

Continued on next page

elect of the Wisconsin Society of OB/GYN and also vice chairman of the Wisconsin Section of the American College of Obstetrics and Gynecology.

James L. Basiliere, MD
Oshkosh
Director, District 5
(1992-1995)
Dr Basiliere was first elected to the Board of Directors in 1986. A board-certified specialist in internal medicine, Dr Basiliere graduated from the University of Wisconsin Medical School in Madison and served an internship and a residency at the San Diego Naval Hospital. He is a past president of the Winnebago County Medical Society, past president of the Fox Valley Academy of Medicine and past secretary of the Oshkosh Area Physicians Association. Dr Basiliere has been a member of the Board of Directors of the Wisconsin Medical Alumni Association since 1988.

Donn D. Fuhrmann, MD
New London
Director, District 5
(1990-1993)
A board-certified family practice specialist, Dr Fuhrmann graduated from the University of Wisconsin Medical School in Madison, and served an internship there as well. He served a residency at St Luke's Hospital in Milwaukee. Dr Fuhrmann is chief of the medical staff at the New London Family Medical Center and is also an assistant clinical professor at the UW Medical School. He has been secretary of the Waupaca County Medical Society since 1982.

Harry J. Zemel, MD
Fond du Lac
Director, District 5
(1991-1994)
Dr Zemel was first elected to the Board in 1987. He graduated from the University of Missouri School of Medicine and specializes in pathology. Dr Zemel has been chair of the Finance Committee since 1989. He is also a member of the Ad Hoc Membership Committee and was president of the Fond du Lac County Medical Society in 1979.

Stephen D. Hathway, MD
Green Bay
Director, District 6
(1992-1995)
A pathologist, Dr Hathway graduated from the Indiana University School of Medicine in Indianapolis and completed an internship and residency at the South Bend Medical Foundation in South Bend, Ind. Dr Hathway is a member of the SMS Health Care Financing and Delivery Committee and served on the Committee on Alcoholism and Other Drug Abuse. He is also a past secretary of the Brown County Medical Society.

Joseph C. DiRaimondo, MD
Manitowoc
Director, District 6
(1991-1994)
Dr DiRaimondo has served on the Board of Directors since 1985. A specialist in orthopedic surgery, he graduated from Washington University Medical School in St Louis and served an internship and residency at University Hospital and Clinics. He served on the SMS Physicians Alliance Commission from 1977 to 1990 and is a past president of the Manitowoc County Medical Society.

John E. Kraus, MD
Marinette
Director, District 6
(1992-1995)
Dr Kraus has been a member of the Board of Directors since 1986. A specialist in internal medicine, he graduated from the University of Buffalo School of Medicine. He served an internship in internal medicine at the Millard Fillmore Hospital in Buffalo and residencies in nephrology at Georgetown University Hospital and the Cleveland Clinic.

Joseph C. DiRaimondo, MD

John J. Kraus, MD

Philip J. Happe, MD

Philip J. Happe, MD
Eau Claire
Director, District 7
(1991-1994)
A specialist in internal medicine, Dr Happe graduated from Creighton University Medical School in Omaha, Neb, and served an internship at Ancker and St Paul Ramsey hospitals in St Paul, Minn. He completed a residency at Creighton University Affiliated Hospital. He is a past president of the Eau Claire-Dunn-Pepin County Medical Society. Dr Happe was first elected to the Board of Directors in 1985 and serves on the Finance Committee.

Lloyd P. Cotts, MD

Robert L. Sellers, MD

Lloyd R. Cotts, MD
Rice Lake
Director, District 7
(1992-1995)
Dr Cotts is a primary care physician associated with the Marshfield Clinic-Indianhead Medical Center. He graduated from the University of Wisconsin Medical School and served his internship at St. Joseph's Hospital, Marshfield. Dr Cotts served on the SMS Commission on Mediation and Peer Review and also served on the WIPRO Board. He has practiced in Rice Lake since 1957 and is a past president of the Barron-Washburn-Burnett County Medical Society.

Robert L. Sellers, MD
Superior
Director, District 8
(1990-1993)
Dr Sellers graduated from the University of Illinois School of Medicine and is in family practice. He is a member of the SMS Finance and Executive committees. In addition, Dr Sellers is a past president of the Douglas County Medical Society.

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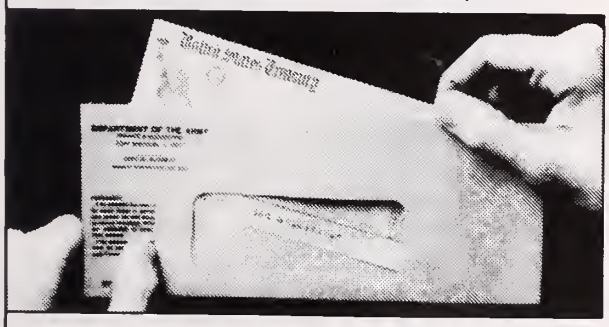

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SMS commissions, committees and task forces: 1992-93

The following is a list of SMS committees, commissions and task forces, and their members for 1992-93. The original year of each member's appointment, as well as the expiration of his or her term, at the annual meeting of the year designated appears with each member's name. Chairs of commissions and committees are appointed for 1-year terms by the Board of Directors. Vice chairs are elected at the first meeting of each commission and committee following the annual meeting. This issue of the WMJ is prepared prior to most of these elections; therefore, some commissions and committees will not include these designations.

Commissions

Continuing Medical Education

This commission shall consist of up to 20 appointed members and the deans of the two medical schools in Wisconsin, or their designees, with vote. It shall be responsible for all matters relating to the whole continuum of medical education, i.e., medical school and residency training as well as lifetime medical learning (continuing medical education). In addition, it shall be responsible for liaison with the medical schools in Wisconsin, their students, residents, fellows and departments of continuing medical education; liaison with specialty societies in the achievement of these goals; liaison with the Commission on Mediation and Peer Review and the Ad Hoc Committee on Health Planning for purposes of implementing continuing medical education programs related to responsibilities and activities of these two groups; and the scientific program of the Annual Meeting. It shall be responsible for accreditation of continuing medical education in hospitals and other institutions or organizations within the state, but shall not be responsible for accreditation of continuing medical education within the state's medical schools.

John W. Beasley, MD, Madison, 1988/1990-1993
Charles E. Holmburg, MD, Menomonee Falls, 1984/1990-1993
James M. Lewis, MD, Baraboo, 1991/1991-1993
George Nemec, Jr, MD, Woodruff, 1987/1990-1993
Benson L. Richardson, MD, Green Bay, 1984/1990-1993
Walter J. Vallejo, MD, La Crosse, 1988/1990-1993
Edward Zupanc, MD, Monroe, 1986/1990-1993
Harold G. Danford, MD, Appleton, 1991/1991-1994
Charles E. Fenlon, MD, Appleton, 1988/1991-1994
Thomas J. Grau, MD, La Crosse, 1991/1991-1994
Arthur G. Norris, MD, Madison, 1991/1991-1994
Elizabeth T. Sanfelippo, MD, Fond du Lac, 1990/1991-1994
Dianne L. Zwicke, MD, Milwaukee, 1987/1991-1994, chair
Edward F. Banaszak, MD, Milwaukee, 1992/1992-1995
Kathy P. Belgea, MD, Wausau, 1984/1992-1995
Vernon N. Dodson, MD, Madison, 1992/1992-1995
Warren J. Holtey, MD, Marshfield, 1990/1992-1995, vice chair
Carlos N. Machicao, MD, Marshfield, 1992/1992-1995
P. Richard Sholl, MD, Janesville, 1992/1992-1995
L. Cass Terry, MD, PhD, Milwaukee, 1990/1992-1995

Medical School Deans' designees:
Thomas C. Meyer, MD, UW-Madison
Timothy J. Van Susteren, PhD, Medical College of Wisconsin

Staff support: Division of Communications

Mediation and Peer Review

This commission shall receive, investigate, and seek to resolve differences between physicians and patients or other complainants, or between physicians, on matters relating to quality of care, and professional ethics. When necessary, it shall initiate disciplinary or other action as appropriate. It shall serve as the Society's advisory body to private or governmental organizations on matters affecting medical peer review including utilization review, appropriateness of care, and quality assurance. It shall advise and consult with component societies on issues of peer review, mediation, ethics, and discipline in concert with members of the Board of Directors. It shall serve as the initial appellate body for peer review and mediation issues that are appealed from local committees of component societies. It shall coordinate the impaired physician program.

Gay R. Anderson, MD, Neenah, 1987/1990-1993
Philip J. Dougherty, MD, Menomonee Falls, 1987/1990-1993
Michael J. O'Neill, MD, Green Bay, 1987/1990-1993
David A. Satchell, MD, Manitowoc, 1990/1990-1993
Joseph C. Tiffany, II, MD, Racine, 1990/1990-1993
Santiago L. Yllas, MD, Racine, 1987/1990-1993
Richard C. Zimmerman, MD, Menomonee Falls, 1984/1990-1993, chair
Bruce B. Berry, MD, Milwaukee, 1991/1991-1994
Vinoo Cameron, MD, Athens, 1991/1991-1994
William V. Dovenbarger, MD, Marshfield, 1985/1991-1994
Donald R. Gore, MD, Sheboygan, 1992/1992-1994
James P. Long, MD, Beloit, 1987/1991-1994
George A. Pagels, MD, Marshfield, 1988/1991-1994
Dorothy V. Skye, MD, Rhinelander, 1985/1991-1994
Frederick W. Blancke, MD, Madison, 1987/1992-1995
Robert M. Green, MD, La Crosse, 1990/1992-1995
John E. Woodford, MD, Madison, 1992/1992-1995

James E. Gutenberger, MD, Madison, 1986/1992-1995
Kenneth O. Johnson, MD, Milwaukee, 1992/1992-1995
Lyle L. Olson, MD, Darlington, 1985/1992-1995
Richard D. Sautter, MD, Marshfield, 1992/1992-1995
Donald F. Weber, MD, Eau Claire, 1992/1992-1995
John B. Weeth, MD, La Crosse, 1992/1992-1995
Virgil L. Sharp, DO, Waterloo, representing the Wisconsin Association of Osteopathic Physicians and Surgeons

Coordinating Council on Physician Impairment
Gerald C. Kempthorne, MD, Spring Green (SMS)
Fred H. Koenecke, Jr, MD, Madison (SMS)
Ann Neviaser, Madison, public member (MEB)
Arthur G. Norris, MD, Milwaukee (SMS)
Clark O. Olsen, MD, Ashland (MEB)
Walter R. Schwartz, MD, Wauwatosa (MEB)

Managing Committee, Statewide Physician Health Program
Pauline M. Jackson, MD, La Crosse
Gerald C. Kempthorne, MD, Spring Green
Fred H. Koenecke, Jr, MD, Madison
Arthur G. Norris, MD, Milwaukee
Wesley E. McNeal, MD, Green Bay
Michael M. Miller, MD, Madison
Marcia J. S. Richards, MD, Milwaukee

Medical Director, SPHP
David G. Benzer, DO, Wauwatosa

Medicaid Medical Audit Committee
R. Marshall Colburn, MD, Oregon
Alfred D. Dally, MD, Madison
John A. DeGiovanni, MD, Prairie du Sac
Philip J. Dougherty, MD, Menomonee Falls
Richard W. Edwards, MD, Richland Center
Charles S. Geiger, Jr, MD, West Bend
John P. Hartwick, MD, Milwaukee
Gerald C. Kempthorne, MD, Spring Green
John J. Kief, MD, Rhinelander
D. Mark Lochner, MD, Waupaca
Bassam M. Rimlawi, MD, Columbus
Virgil L. Sharp, DO, Waterloo, representing the Wisconsin Association of Osteopathic Physicians and Surgeons
G. John Weir, Jr, MD, Marshfield

Staff support: Office of Legal Services

Physicians Alliance
This commission shall plan, organize, and implement programs to protect and preserve the legislative, socioeconomic, and political interests of the members of the State Medical Society of Wisconsin. The commission shall analyze state and federal legislation and administrative rules and policies, and

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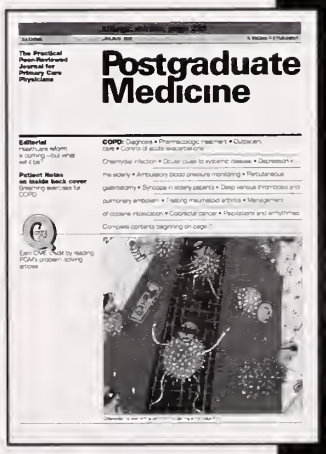

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Postgraduate Medicine

Continued from preceding page
recommend to the Board of Directors specific actions and positions designed to carry out this responsibility. The commission shall also inform the membership of the Society regarding proposed legislation and other public policy initiatives, seek the enactment of legislation for the best interests of the public, scientific medicine, and the medical profession, and promote and encourage Society members to be politically active individually and collectively. This commission shall act to protect the socioeconomic interests of the Society membership in public and private health care delivery systems and recommend to the Board of Directors specific strategies and efforts to achieve this purpose. This commission shall consist of members appointed by the Board of Directors in a number deemed sufficient to execute the responsibilities delegated to the commission. Membership on the commission shall also include a representative from each of the specialty sections of the Society, subject to approval by the Board of Directors. These representatives shall be appointed by the sections annually, and shall have the right to vote on all matters before the commission. The President, President-elect, Immediate Past President, and Chairman of the Board of the Society shall serve as ex officio members of the commission with vote.

Mark H. Andrew, MD, Viroqua, 1990/1990-1993
Steven K. Dankle, MD, Milwaukee, 1990/1990-1993
Vernon N. Dodson, MD, Madison, 1985/1990-1993
Ronald L. Harms, MD, Shawano, 1985/1990-1993
Timothy G. McAvoy, MD, Waukesha, 1987/1990-1993
Robert M. Stern, MD, Milwaukee, 1990/1990-1993
L. Cass Terry, MD, Milwaukee, 1990/1990-1993
DeLore Williams, MD, Elm Grove, 1985/1990-1993
Gregory B. Buck, MD, Wauwatosa, 1990/1991-1994
Thomas A. Handrich, MD, Mequon, 1992/1992-1994
Randall J. Kieser, MD, Madison, 1991/1991-1994
Bruce A. Kraus, MD, Columbus, 1988/1991-1994
Michael C. Reineck, MD, West Bend, 1984/1991-1994, chair
Thomas Slota, MD, Milwaukee, 1992/1992-1994
Charles L. Steidinger, MD, Platteville, 1983/1991-1994
Sheldon A. Wasserman, MD, Milwaukee, 1992/1992-1994
Carl S. Eisenberg, MD, Milwaukee, 1984/1992-1995
Pauline M. Jackson, MD, La Crosse, 1989/1992-1995
Michael J. Kryda, MD, Marshfield, 1989/1992-1995
Larry M. Ojeda, MD, Beloit, 1989/1992-1995
Michael P. Mehr, MD, Marshfield, 1985/1992-1995
Bernard F. Micke, MD, Madison, 1986/1992-1995
Joseph E. Trader, MD, Manitowoc, 1989/1992-1995
Kevin Hayden, Superior, WMGMA representative
Jeri Cushman, Racine, Auxiliary

President: William J. Listwan, MD, West Bend
President-elect: Pauline M. Jackson, MD, La Crosse
Immediate Past President: Cyril M. Hetsko, MD, Madison
Chairman of the Board: Richard H. Ulmer, MD, Marshfield

Section representatives
Allergy Section: Donald A. Bukstein, MD, Madison
Anesthesiology Section: John F. Kreul, MD, Madison
Dermatology Section: David K. Falk, MD, Madison
Emergency Medicine Section: Thomas J. Luetzow, MD, Larsen
Family Physicians Section: Jack Strong, MD, Mauston
Internal Medicine Section: Susan L. Turney, MD, Marshfield
Neurology Section: Gamber F. Tegtmeyer, Jr, MD, Madison
Neurosurgery Section: Mohammed Rafiullah, MD, Racine
Obstetrics-Gynecology Section: Robert K. DeMott, MD, Green Bay
Ophthalmology Section: Jack L. Hughes, MD, Wauwatosa
Orthopaedic Section: Robert O. Buss, MD, Elm Grove
Pathology Section: Roland C. Brown, MD, West Bend
Pediatrics Section: Kathryn P. Nichol, MD, Madison
Physical Medicine & Rehabilitation Section: Donna D. Davidoff, MD, Mequon
Plastic Surgery: Benjamin A. VanRaalte, MD, Waukesha
Psychiatry: Robert F. Goerke, MD, Milwaukee
Radiation Oncology Section: Howard J. Lewis, MD, Milwaukee

(Other Section Representatives to be appointed)

Staff support: Division of Public Affairs and Division of Medical Policy and Practice

Public Information
This commission shall be concerned about the members of this Society and their image with the public. It shall plan and execute programs of effective public information and health education, assist component societies in the conduct of similar programs, develop effective media relations.

Arthur G. Barbier, MD, La Crosse, 1984/1990-1993
Fred J. Bartizal, Jr, MD, Neenah, 1988/1990-1993
Paul D. Nelsen, MD, Green Lake, 1984/1990-1993, chair
Clarence P. Chou, MD, Mequon, 1991/1991-1994
Judith E. Fitzgerald, MD, Madison, 1991/1991-1994
Bradley L. Manning, MD, Madison, 1991/1991-1994
Benjamin C. Wedro, MD, La Crosse, 1987/1991-1994
P. Richard Sholl, MD, Janesville, 1990/1992-1995
David R. Del Toro, MD, Greenfield, 1992/1992-1995
Don Anderson, medical student, UW
Jean Lawrence, Fond du Lac, Auxiliary

Staff support: Division of Communications

Wisconsin Medical Journal
The *Wisconsin Medical Journal* shall be the official journal of the Society. An editorial board consisting of the medical editor as chair and no less than six additional members shall be responsible for all scientific, editorial, and business affairs of the Journal. An editorial director, serving as chair of a group of no less than five editorial associates, shall be

responsible for regularly providing items of editorial opinion for publication in the editorial pages of the Journal.

Richard D. Sautter, MD, Marshfield, 1990/1992-1993, chair and medical editor
Susan F. Behrens, MD, Beloit, 1991/1991-1993
Thomas H. Cogbill, MD, La Crosse, 1987/1990-1993
Andrew B. Crummy, Jr, MD, Madison, 1985/1991-1994
Donald S. Schuster, MD, Madison, 1991/1991-1994
J D Kabler, MD, Madison, 1989/1992-1995
Jeffrey H. Lamont, MD, Wausau, 1989/1992-1995
Richard A. Reinhart, MD, Marshfield, 1989/1992-1995
Victor S. Falk, MD, Edgerton, medical editor emeritus

Editorial associates
(Appointed annually by Board of Directors.)
Kenneth I. Gold, MD, Beloit
Russell F. Lewis, MD, Marshfield
John P. Mullooly, MD, Milwaukee
Richard D. Sautter, MD, Marshfield
John D. Wegenke, MD, Madison
Maxwell H. S. Weingarten, MD, Milwaukee

Staff support: Division of Communications

Committees

Aging, Extended Care Facilities, and Home Health Care
This committee shall be concerned about the process of aging and means to achieve the best possible health care for the aged, including nursing home care and home care.

Robert E. Phillips, MD, Marshfield, 1982/1990-1993
Mark A. Sager, MD, Madison, 1990/1990-1993
Thomas H. Williams, MD, Mukwonago, 1987/1990-1993
Edward R. Winga, MD, La Crosse, 1982/1990-1993
Steven G. Brown, MD, Menomonie, 1991/1991-1994
Paul E. Hankwitz, MD, Milwaukee, 1985/1991-1994, chair
Richard S. Kane, MD, Milwaukee, 1989/1991-1994, vice chair
Edward O. Lukasek, MD, Sparta, 1988/1991-1994
Joseph N. Blustein, MD, Madison, 1992/1992-1995
Bruce A. Kraus, MD, Columbus, 1990/1992-1995
Walter Lewinnek, MD, Merrill, 1992/1992-1995
Ronald Menaker, Marshfield, WMGMA representative
Sandra Kontra, Racine, Auxiliary

Staff support: Division of Medical Policy and Practice

Alcoholism and Other Drug Abuse
This committee shall be concerned about prevention, treatment, and rehabilitation for persons affected by alcoholism and any other type of drug abuse.

Michael G. Deeken, MD, Wauwatosa, 1990/1990-1993
Thomas P. Koehler, MD, Green Bay, 1991/1991-1993
Fred H. Koenecke, Jr, MD, Madison, 1990/1990-1993
Michael M. Miller, MD, Madison, 1990/1990-1993
Raymond W. Moy, MD, Milwaukee, 1990/1990-1993
David Benzer, DO, Wauwatosa, 1985/1991-1994, chair
John R. Gladieux, MD, Milwaukee, 1988/1991-1994
Brian E. Lochen, MD, Madison, 1991/1991-1994
Edward O. Lukasek, MD, Sparta, 1986/1991-1994
Randall J. Kieser, MD, Madison, 1992/1992-1995, vice chair
Michael S. Levy, DO, Brookfield, 1992/1992-1995
Thomas H. Peterson, MD, Wausau, 1989/1992-1995
Anne M. G. Schierl, MD, Stevens Point, 1989/1992-1995
Sherry Stormo, Fond du Lac, Auxiliary

Staff support: Division of Medical Policy and Practice

Environmental and Occupational Health
This committee shall be concerned with the health and safety of persons in relation to their environment, including matters relating to occupational and rural health.

John T. Bolger, MD, Waukesha, 1990/1990-1993
Robert J. Braco, MD, Neenah, 1992/1992-1993

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Continued from preceding page
Raymond R. Johnson, MD, Wauwatosa, 1984/1990-1993
J. Steven Moore, MD, Brookfield, 1985/1990-1993
Charles A. Capasso, MD, Neenah, 1986/1991-1994, chair
Paul F. Durkee, MD, Janesville, 1985/1991-1994
Julie N. Larsen, MD, Oconomowoc, 1992/1992-1994
James T. Paloucek, MD, Milwaukee, 1985/1991-1994
John J. Ouellette, MD, Madison, 1991/1991-1994
Mark A. Roberts, MD, Milwaukee, 1991/1991-1994
Henry A. Anderson, MD, Madison, 1992/1992-1995
James L. Basiliere, MD, Oshkosh, 1989/1992-1995
Jane K. Sliwinski, MD, Green Bay, 1990/1992-1995
Sridhar V. Vasudevan, MD, Brookfield, 1989/1992-1995
Carl Zenz, MD, West Allis, 1986/1992-1995
Susan M. Abell, Kenosha, WMGMA representative
Betty Kuplic, Sheboygan, Auxiliary

Staff support: Division of Medical Policy and Practice

Health Care Financing and Delivery Committee
This committee shall be concerned about all aspects of health care financing and delivery systems, including managed health care plans, and shall promote an ongoing dialogue on these issues with business, industry, labor and, when appropriate, government agencies.

Edward J. Coleman, MD, Green Bay, 1992/1992-1993
Kay E. Jewell, MD, Madison, 1990/1990-1993
Stuart R. Lancer, MD, Eau Claire, 1992/1992-1993
Russell F. Lewis, MD, Madison, 1982/1990-1993
Rudolf W. Link, MD, Lodi, 1990/1990-1993
William C. Miller, MD, Wausau, 1982/1990-1993
Roger L. von Heimburg, MD, Green Bay, 1991/1991-1993
Michael J. Wempe, MD, Kenosha, 1990/1990-1993
Richard H. Christenson, MD, Milwaukee, 1986/1991-1994, vice chair
Clyde M. Chumbley, II, MD, Menomonee Falls, 1991/1991-1994
Alfred D. Dally, MD, Madison, 1989/1991-1994
Charles S. Geiger, Jr, MD, West Bend, 1991/1991-1994
Charles V. Ihle, MD, Eau Claire, 1992/1992-1994
Guenther P. Pohlmann, MD, Milwaukee, 1989/1991-1994
Norman J. Schroeder, II, MD, Green Bay, 1989/1991-1994
William L. Treacy, MD, Milwaukee, 1991/1991-1994
Paul G. Harkins, MD, Marshfield, 1990/1992-1995
Stephen D. Hathway, MD, Green Bay, 1986/1992-1995
Jerry M. Ingalls, MD, Monroe, 1989/1992-1995
Peter L. Loes, MD, Rhinelander, 1991/1992-1995
Kermit L. Newcomer, MD, La Crosse, 1987/1992-1995, chair
Warren H. Williamson, MD, Racine, 1984/1992-1995
Joan Albian, Milwaukee, WMGMA representative
Erik Gundersen, medical student, UW

Medical Assistance Technical Advisory Committee
(subcommittee)

Richard H. Christenson, MD, Milwaukee
Daniel D. Gilman, DO, Milwaukee
Marc F.Hansen, MD, Madison
Russell F. Lewis, MD, Madison
Wayman Parker, MD, Milwaukee
Guenther P. Pohlmann, MD, Milwaukee
Jack Strong, MD, Mauston
Warren H. Williamson, MD, Racine, chair
Tom Blinn, Madison, Physicians-Plus Medical Group
Kevin Hayden, Superior, Mariner Medical Clinic
Kevin Piper, Madison, DHSS
Alan Ulrich, Neenah, La Salle Clinic

Staff support: Division of Medical Policy and Practice

Maternal and Child Health
This committee shall be concerned about all aspects of health in pregnancy, childbirth and children, with special emphasis on the reduction of maternal mortality and the prevention of disease or disability in children.

Patricia M. Barwig, MD, Milwaukee, 1990/1990-1993
Susan C. Fee, MD, Marshfield, 1991/1991-1993
Robert J. Jaeger, MD, Stevens Point, 1984/1990-1993, chair
Timothy J. O'Neil, MD, Columbus, 1991/1991-1993
Steven D. Stenzel, MD, Eau Claire, 1991/1991-1993
Charles A. Hammond, MD, Neenah, 1985/1991-1994
Perry A. Henderson, MD, Madison, 1985/1991-1994
John E. Inman, MD, Monroe, 1991/1991-1994
Murray L. Katcher, MD, PhD, Madison, 1988/1991-1994
John D. Kenny, MD, Madison, 1987/1991-1994, vice chair
James A. Meyer, MD, Marshfield, 1988/1991-1994
Jerome H. Gundersen, MD, La Crosse, 1989/1992-1995
Robert J. Miller, MD, Hales Corners, 1992/1992-1995
Paul R. Myers, MD, Neenah, 1992/1992-1995
Ordean L. Torstenson, MD, Madison, 1989/1992-1995
Tom Murwin, medical student, UW
Roberta Baldwin, Watertown, Auxiliary

Study Committee on Maternal Mortality Survey
Everett A. Beguin, MD, La Crosse
Gloria M. Halverson, MD, Waukesha, chair
Perry A. Henderson, MD, Madison
Frederick J. Hofmeister, MD, Wauwatosa
John E. Inman, MD, Monroe
Robert J. Jaeger, MD, Stevens Point
Dan F. Johnson, MD, Eau Claire
Stanley A. Korducki, MD, Milwaukee
Paul R. Meier, MD, Marshfield
Ronald W. Olson, MD, Madison
Bernard B. Poeschel, MD, Eau Claire
Herbert F. Sandmire, MD, Green Bay
Walter R. Schwartz, MD, Wauwatosa
Dorothy V. Skye, MD, Rhinelander
Steven D. Stenzel, MD, Eau Claire

E. Howard Theis, MD, Fond du Lac
Dennis Worthington, MD, Milwaukee
Richard C. Brown, MD, Eau Claire, emeritus

Staff support: Division of Medical Policy and Practice

Medical Liability
The purpose of this committee shall be to monitor current liability developments and to examine a series of options and alternatives relative to a long-range solution of the medical liability problems, reporting to the Board of Directors.

Bruce B. Berry, MD, Milwaukee, 1989/1990-1993
Jerome W. Fons, Jr, MD, Greenfield, 1989/1990-1993
William J. Listwan, MD, West Bend, 1987/1990-1993
Herbert F. Sandmire, MD, Green Bay, 1987/1990-1993
Carolyn Ogland Vukich, MD, Madison, 1991/1991-1993
Robert S. Witte, MD, La Crosse, 1991/1991-1993
S. Marshall Cushman, Jr, MD, Racine, 1988/1991-1994
Lucille B. Glicklich, MD, Milwaukee, 1987/1991-1994
Thomas M. Kidder, MD, Milwaukee, 1987/1991-1994, chair
Michael C. Reineck, MD, West Bend, 1987/1991-1994
Luther M. Strayer, III, MD, Neenah, 1989/1991-1994
Joseph C. DiRaimondo, MD, Manitowoc, 1990/1992-1995
Charles F. Dungar, MD, Appleton, 1987/1992-1995
Sidney E. Johnson, MD, Marshfield, 1987/1992-1995
Steven L. Lawrence, MD, Milwaukee, 1989/1992-1995
Richard G. Roberts, MD, Madison, 1987/1992-1995
Alice Soule, Madison, WMGMA representative
Jackie Dungar, Appleton, Auxiliary

Staff support: Division of Medical Policy and Practice

Medicine and Ethics
This committee shall be concerned with the ethical aspects of medical practice in order to permit discussion of commom problems in the total treatment and care of patients; and, to clarify the relationship between ethics and science in medicine.

James E. Glasser, MD, La Crosse, 1987/1990-1993
John C. Jordan, MD, Richland Center, 1985/1990-1993
Charles L. Junkerman, MD, Milwaukee, 1990/1990-1993, chair
J D Kabler, MD, Madison, 1990/1990-1993, vice chair
John P. Mullooly, MD, Milwaukee, 1989/1990-1993
Philip H. Utz, MD, La Crosse, 1987/1990-1993
Philip J. Dougherty, MD, Menomonee Falls, 1991/1991-1994
Scott S. Erickson, MD, Marshfield, 1987/1991-1994
John K. Scott, MD, Madison, 1990/1991-1994
Rodney Sorensen, DO, Marshfield, 1987/1991-1994
William G. Weber, MD, Oshkosh, 1991/1991-1994
James F. Zimmer, MD, Hales Corners, 1991/1991-1994
Donald R. Beaver, DO, Milwaukee, 1992/1992-1995
Wm. Michael Cross, MD, Green Bay, 1992/1992-1995
Michael N. Katzoff, MD, Milwaukee, 1992/1992-1995
David J. Matteucci, MD, Kenosha, 1989/1992-1995
Richard J. Thurrell, MD, Madison, 1990/1992-1995
Miep Kempthorne, Spring Green, Auxiliary

Staff support: Division of Medical Policy and Practice

Membership (ad hoc)
This committee shall function as a sounding board for programs, plans, strategies to address expansion of SMS membership, as well as to evaluate membership campaigns and existing SMS programs. It reports to the Board of Directors.

Mark H. Andrew, MD, Viroqua
Timothy T. Flaherty, MD, Neenah, chair
Richard D. Fritz, MD, Milwaukee
Carlos A. Jaramillo, MD, Monroe
Harry J. Zemel, MD, Fond du Lac
John A. Nemec, La Crosse, WMGMA representative

Mental Health
This committee shall be concerned with all aspects of mental

Continued on next page

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Continued from preceding page
health as an equal part of the patient's total well-being.

Robert E. O'Connor, MD, Madison, 1990/1990-1993
Leonard J. Ganser, MD, Madison, 1991/1991-1993
Robert B. Shapiro, MD, Madison, 1983/1990-1993
Donald L. Feinsilver, MD, Milwaukee, 1985/1991-1994
James F. Land, MD, Madison, 1991/1991-1994
Wess R. Vogt, MD, Mequon, 1985/1991-1994
Pauline M. Jackson, MD, La Crosse, 1989/1992-1995, chair
Margaret J. Seay, MD, Oshkosh, 1985/1992-1995
Laurens D. Young, MD, Milwaukee, 1987/1992-1995
Pixie Litt, Green Bay, WMGMA representative
Katie Webster, La Crosse, Auxiliary

Staff support: Division of Medical Policy and Practice

Safe Transportation
This committee shall be concerned with the health and safety of all who may be affected by the use of vehicles of transportation on land, water, or in the air. This includes the responsibility to review the emergency medical systems in Wisconsin that serve the needs of those injured in transportation accidents.

Thomas H. Cogbill, MD, La Crosse, 1991/1991-1993
Phiroze L. Hansotia, MD, Marshfield, 1992/1992-1993
Ralph F. Hudson, MD, Eau Claire, 1989/1990-1993
Kathryn P. Nichol, MD, Madison, 1982/1990-1993
Kay M. Balink, MD, Richland Center, 1992/1992-1994
Stephen W. Hargarten, MD, Milwaukee, 1985/1991-1994, chair
Susan Kinast-Porter, MD, Monroe, 1985/1991-1994
Raymond E. Skupniewicz, MD, Racine, 1990/1991-1994
Richard D. Lindgren, MD, Madison, 1986/1992-1995
Thomas J. Luetzow, MD, Larsen, 1986/1992-1995
William H. Perloff, MD, Madison, 1992/1992-1995
Sherri Bush, Beaver Dam, Auxiliary

Staff support: Division of Medical Policy and Practice

School Health
This committee shall be concerned about maintaining and improving the health of those attending the public or private schools of this state, including matters related to athletics.

Paul F. Dvorak, MD, Madison, 1990/1990-1993
Jeffrey H. Lamont, MD, Wausau, 1987/1990-1993, chair
Rolf L. Simonson, MD, Sheboygan, 1982/1990-1993
James S. Janowiak, MD, Merrill, 1985/1991-1994
Charles H. Miller, III, MD, La Crosse, 1988/1991-1994
Louis J. Ptacek, MD, Marshfield, 1988/1991-1994
Natalie L. Gehringer, MD, Menasha, 1986/1992-1995
Patricio F. Viernes, MD, Brookfield, 1987/1992-1995
Victoria A. Vollrath, MD, Madison, 1989/1992-1995
Mary Smigielski, Milwaukee, Auxiliary
Sherry Stormo, Fond du Lac, Auxiliary

WIAA Medical Advisory Committee
Conrad L. Andringa, MD, Madison, chair
Phillips T. Bland, MD, Westby
James H. DeWeerd, Jr, MD, Stevens Point
Frederick W. Gissal, MD, Wisconsin Dells
Ronald L. Harms, MD, Shawano
Rolf S. Lulloff, MD, Green Bay
Kermit L. Newcomer, MD, La Crosse
John K. Scott, MD, Madison
Elizabeth A. Steffen, MD, Racine

Staff support: Division of Medical Policy and Practice

WNA-SMS Liaison
In 1987 the Nurse Physician Liaison Committee was renamed the WNA-SMS Liaison Committee. This committee shall be concerned with developing recommendations, as appropriate, regarding education, legislation, practice arrangements and delivery patterns; shall facilitate understanding and acceptance by the professions and the public of changing medical and nursing relationships, roles and practices; shall serve as a consultation resource in matters that relate to joint practice.

SMS members:
Albert J. Motzel Jr, MD, Waukesha, 1987/1990-1993
Sandra L. Osborn, MD, Madison, 1990/1990-1993, co-chair
Kenneth I. Gold, MD, Beloit, 1992/1992-1994
Robert T. Cooney, MD, Portage, 1987/1992-1995
Marc F. Hansen, MD, Madison, 1987/1992-1995

WNA members:
Susan Bulgrin, RN, Portage
Barbara Friedbacher, RN, Brookfield
Vickie Gukenberger, RN, Wisconsin Rapids
Sherry Quamme, RN, Columbus
Leona VandeVusse, RN, Milwaukee

Staff support: Office of Legal Services

Task forces

Task Force on AIDS
In 1987 the Board of Directors established this task force to advise members of the State Medical Society on the formulation of public policy to address the scientific, medical, ethical, legal, and legislative issues pertaining to AIDS.

SMS members:
Patricia M. Barwig, MD, Milwaukee
Gerald J. Dorff, MD, Milwaukee
John F. Doyle, DDS, Madison

Charles E. Gessert, MD, Milwaukee
Ian H. Gilson, MD, Milwaukee
Jerome H. Gundersen, MD, La Crosse
Cyril M. Hetsko, MD, Madison, chair
Stanley L. Inhorn, MD, Madison
Charles L. Junkerman, MD, Milwaukee
J. Douglas Lee, MD, Marshfield
Richard M. Reich, MD, Madison
Thomas L. Schlenker, MD, Milwaukee
Jeffrey E. Taxman, MD, Milwaukeke
Louise Scott, Madison, Auxiliary

WHA member:
Jane Olson, WHA, Madison
Special advisory members:
Jeffrey P. Davis, MD, Madison
James M. Vergeront, MD, Madison

Staff support: Division of Public Affairs

Task Force on Domestic Violence
This task force shall consist of appointed Wisconsin physicians with interest and expertise in regard to issues of domestic violence. The task force shall be concerned with helping members address domestic violence through their practices and shall serve as a facilitator within the physician community, encouraging discussion of ways to increase identification, treatment and prevention of domestic violence. The task force shall also be responsible for keeping members of the Medical Society apprised of recent developments in terms of effective interventions which benefit victims of domestic violence.

Richard A. Aronson, MD, Madison
Patricia M. Barwig, MD, Milwaukee
Mark K. Chelmowski, MD, Milwaukee
Richard L. Ellis, MD, Middleton
Kevin J. Fullin, MD, Kenosha
Susan Kinast-Porter, MD, Monroe
Larry E. La Crosse, MD, Mequon
William J. Listwan, MD, West Bend, chair
Joanne A. Selkurt, MD, Whitehall
Paul H. Steingraeber, MD, La Crosse
Fe Abellera, Onalaska, Auxiliary
Leah Speltz, Wausau, Auxiliary

Staff support: Division of Communications

Task Force on Health Care Reform
The purpose of this task force is to develop a plan for Wisconsin's future health care system.

John W. Beasley, MD, Madison
Carl J. Getto, MD, Madison
Duane M. Koons, MD, Viroqua
Bradley L. Manning, MD, Madison
Kathryn P. Nichol, MD, Madison
John R. Petersen, MD, Milwaukee
Robert E. Phillips, MD, Marshfield
Marcia J. S. Richards, MD, Milwaukee
John K. Scott, MD, Madison
Robert L. Sellers, MD, Superior
Kenneth M. Viste, Jr, MD, Oshkosh, chair
Roger L. von Heimburg, MD, Green Bay

Staff support: Division of Medical Policy and Practice

Committees of the Board

Executive
William J. Listwan, MD, West Bend, chair
president of the Society
Pauline M. Jackson, MD, La Crosse
president elect of the Society
Cyril M. Hetsko, MD, Madison
immediate past president of the Society
Richard H. Ulmer, MD, Marshfield
chair of the Board
Raymond C. Zastrow, MD, Milwaukee
vice chair of the Board
Harry J. Zemel, MD, Fond du Lac
chair of the Finance Committee
Richard G. Roberts, MD, Madison
speaker of the House of Delegates
Robert F. Purtell, Jr, MD, Milwaukee
director at large
Robert L. Sellers, MD, Superior
director at large
Ex Officio non-voting members:
Fe Abellera, Onalaska
Auxiliary president
Leah Speltz
Auxiliary president elect

Finance
Harry J. Zemel, MD, Fond du Lac, chair
Philip J. Happe, MD, Eau Claire
Stephen D. Hathway, MD, Green Bay
Jack M. Lockhart, MD, La Crosse
Thomas A. Reminga, MD, Milwaukee
Robert L. Sellers, MD, Superior
Raymond C. Zastrow, MD, Milwaukee

Executive Compensation
Richard H. Ulmer, MD, Marshfield, chair
Harry J. Zemel, MD, Fond du Lac
Cyril M. Hetsko, MD, Madison

Expense reimbursement policy and procedure for physicians on SMS business

It is SMS policy to offer reimbursement of out-of-pocket expenses incurred by its officers, directors, committee chairs and members, AMA delegates and alternates and other designated physicians when such expenses are incurred in the course of the conduct of business on behalf of the society. The society recognizes that any such leadership role requires a substantial contribution in personal time on the part of the physician. Traditionally, this has been accepted as a contribution to the profession and the health of the public. Out-of-pocket expenses in the discharge of official functions of the society are, however, reimbursable as set forth below, except that district directors are not reimbursed for the expense of attending the annual meeting of the society (Bylaws, Chapter V, Sec 4).

Officers, directors, committee chairs and members, and other designated persons

Reimbursable expenses include the cost of:

- All meals, including normal tips, incurred while away from the physician's home city on SMS business.
- All meals in the home city of the physician when these are in relation to an SMS business meeting.
- Entertainment expenses where such expense is clearly a proper and necessary adjunct to the conduct of the physician's business function for the society.
- Valet and laundry services when the physician is away from home city on SMS business continuously for 4 days or more.
- Lodging for those days (nights) reasonably associated with the dates of a meeting for which expenses are claimed.
- Transportation from home city to meeting site and return as follows:

  Air. Cost of round trip coach airfare, plus necessary ground transportation.

  Bus or train. Cost of round trip fare, plus necessary ground transportation.

  Auto. Mileage at the current SMS rate (now $.28) to and from the meeting site, plus necessary parking fees and highway tolls.

  Miscellaneous ground transportation. Local bus and cab fares as necessary.

  Auto rental. All or some portion of such cost may be reimbursed as a substitute for other ground transport when this is the most feasible alternative following initial air, bus or train travel.
- Telephone, fax and telegraph communications relative to SMS business.
- Secretarial and copying services, postage and stationary used for SMS business. (Note: SMS headquarters is prepared to handle most official correspondence and reproduction work for officers and committee members. Physicians may be reimbursed, however, for personal or office costs relating to secretarial, copying, postage and stationery used in conducting SMS business. Copies of all official correspondence should be sent to the appropriate committee staff person at SMS, so as to assure proper coordination and record-keeping.
- Expenses, as described above, incurred by the president's and president elect's spouses when accompanying in an official capacity, or when the spouse is expected to be in attendance, are reimbursable.

Procedure for claiming expenses. To obtain reimbursement, submit a statement of expenses incurred. Attach copies of bills or receipts for all lodging, travel, and meals over $25. Itemize separately costs for the eighth item above. Mail to SMS Business Services and Support, PO Box 1109, Madison, WI 53701. Reimbursement will be made within two weeks following receipt and approval of the expense report.

AMA delegates and alternates

AMA delegates and alternates (including the young physicians delegate and alternate) from Wisconsin receive reimbursement as follows for each meeting to the AMA House of Delegates they attend:

- Round trip economy air fare (advance booking strongly suggested.)
- Actual cost of room (mid-range) for 5 nights at the annual meeting, and 4 nights at the interim meeting.
- A per diem (currently $60) for food and all incidentals for 6 days at the annual meeting, and 5 days at the interim meeting.
- When AMA delegates and alternates are conducting SMS business not in conjunction with meetings of the AMA House of Delegates, their expenses may be reimbursed in the same manner as outlined for officers and directors.

Out-of-state trips

With the exception of travel to the AMA House of Delegates meetings and travel of the SMS president and president elect, all out-of-state trips must have prior approval by the Executive Committee to be reimbursable. Contact the executive vice president.[150th]

Questions?

Call the SMS

toll-free

1-800-362-9080.

SMS financial report

The following financial statements of the State Medical Society of Wisconsin are part of the treasurer's report to the House of Delegates. The annual certified audit, prepared by Grant Thornton, independent certified public accountants, is on file at Society headquarters. Members may review the audit by inquiry to the SMS executive vice president/ secretary.

SMS general fund balance sheet
Dec 31, 1991

Assets	
Current assets	
Cash and cash equivalents	$ 3,620,365
Investments	1,188,176
Accounts receivable	
Trade	55,594
Due from affiliates	21,689
Investment revenues receivable	4,192
Inventories	7,994
Prepaid expenses	48,513
Total current assets	$ 4,946,523
Property and equipment—at cost	
Building and equipment	$ 2,518,570
Furniture and equipment	1,204,280
Capitalized Lease Equipment	225,820
Less accumulated depreciation	(1,493,967)
Land	52,875
Total property and equipment	$ 2,507,578
Other assets	
Rental property, net of accumulated depreciation of $71,906	$ 1,391,411
Prepaid pension costs	354,424
Long-term investment	249,000
Cash value of life insurance	2,311
Investment in subsidiary	365,088
Deferred compensation plan assets	196,639
Notes Receivable	100,000
Total other assets	$ 2,658,873
Total assets	$10,112,974
Liabilities	
Current liabilities	
Current maturities of long-term debt	$ 147,788
Trade accounts payable	108,295
Dues payable to other organizations	981,903
Accrued payroll and vacation pay	86,002
Accrued property, payroll and sales taxes	163,621
Deferred revenues	2,575,429
Accrued health plan costs	32,779
Other	26,926
Total current liabilities	$ 4,122,743
Long-term debt less current maturities	$ 2,478,678
Deferred compensation payable	$ 196,639
Membership equity	$ 3,314,914
Total liabilities and membership equity	$10,112,974

Statement of income and expense
Year ended Dec 31, 1991

Income	
Membership dues	$ 2,946,906
Sales and services	1,010,612
Investment income	405,282
Royalty income	253,745
Gain on sale of investments	52,409
Loss on disposal of property and equipment	(1,459)
Rental	290,326
AIDS regional education and training center grant	137,570
Other grants	99,145
Total income	$ 5,194,536
Expenses	
Payroll and employee benefits	$ 2,329,083
Travel and conference	511,411
General and administrative	967,013
Occupancy	363,309
Professional fees and outside services	304,919
AIDS regional education and training center grant	137,570
Interest expense	267,156
Taxes	(2,088)
Total expenses	$ 4,878,373
Excess of revenues over expenses	$ 316,163
Equity at Jan 1, 1991	$ 3,049,934
Equity in loss of subsidiary	$ (51,183)
Equity at Dec 31, 1991	$ 3,314,914

150th

Charter law of the SMS

Chapter 148

148.015 State society.(1) The State Medical Society of Wisconsin is continued with the general powers of a corporation. It may, from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 County societies. (1) The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists, may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the medical examining board, shall be entitled to meet for organization or become members of the county medical society.

(3) If there is not a sufficient number of physicians and surgeons in any county to form a county medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than 15 adjoining counties may organize a county medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, bylaws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 Service insurance corporations for health care. The state medical society or, in a manner approved by the state society, a county society, may establish in one or more counties of this state a service insurance corporation for health care under ch. 613.

Note on §148.03, 447.13, and 449.15: Chapter 613 provides in general terms for the creation, governance and regulation of service insurance corporations for any kind of health care, as well as for other types of services. All that is needed in each authorizing chapter for professional societies is a brief section giving the appropriate professional society the power to organize a ch. 613 corporation. Section 148.03 creates that section for health care.

One basic restriction results from the repeal of the old enabling sections: none of the professional societies will be able to organize a service insurance plan within its own corporate structure. It is a mistake to permit such a mixing of professional and insurance activities within the same corporation. The society can, of course, control the service insurance corporation it creates under ch. 613, but the service insurance corporation will be legally separate. This will lead to more effective (and appropriate) control by the insurance commissioner, who should neither be empowered nor compelled, as arguably he was under the old statutes, to have any concern about the purely professional activities of the societies, because of the impossibility of disentangling the insurance and professional activities carried on by a single corporation.

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SMS Constitution and Bylaws

Constitution

Article I
Name of the association

The name and title of this organization shall be the State Medical Society of Wisconsin.

Article II
Purpose

The purpose of the Society is to bring together the physicians of the state of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws. As used in the Constitution and Bylaws, "physician" means a doctor of medicine or a doctor of osteopathy licensed in Wisconsin.

Article III
Component societies

Component societies shall consist of those county medical societies chartered by the House of Delegates of this Society.

Article IV
Composition of the association

This Society shall consist of members who shall be the members of and certified by the component county medical societies; and whose dues and assessments for the current year have been received by the Society secretary in accordance with the schedule provided in the Bylaws.

Article V
House of Delegates

The House of Delegates shall be the legislative body of the Society and shall consist of:

(1) delegates elected by the component county medical societies,
(2) one delegate representing each specialty section of the Society organized under the Bylaws,
(3) a speaker,
(4) a vice speaker.

The officers of the Society enumerated in Article IX of this Constitution, directors, and past presidents of the Society shall be ex officio members, but without the right to vote, except that if they have been duly seated as delegates, they shall have the right to vote. The speaker and vice speaker shall be elected by and from the House of Delegates for two-year terms, and shall be limited to three consecutive full terms in their respective offices. While holding these offices, they shall be members of the House at large and shall not represent any component county society or specialty society.

Article VI
Board of Directors

The Board of Directors, hereinafter referred to as "Board," shall have full authority and power of the House of Delegates between sessions of the House. It shall consist of the directors, immediate past president, president, president-elect, speaker and vice speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Board, but without the right to vote. A majority of its voting members shall constitute a quorum. Directors shall be elected from eight geographic districts whose boundaries shall be determined by the House of Delegates. There shall be elected one director from each district. In addition, there shall be elected director(s) from each district based on a formula using the number of members in each district as the numerator and the total membership of the Society as the denominator, rounded to the nearest whole number. This calculation shall be made every third year, and, as nearly as possible, is to provide for no more than 31 district directors and shall be based on the year end membership totals. The number of directors established for each district shall be approved by the Board and shall be reported to the districts by the secretary before annual elections to the Board. As nearly as possible, one-third of the members of the Board shall be elected each year. Each director shall be nominated and elected only by the elected delegates of the county medical society of societies from the district in which the director's principal place of practice is located. Such election shall be subject to the approval and confirmation of the House of Delegates. The terms of the directors shall be for three years. No individual shall be permitted to serve more than three consecutive three-year terms as director, and no more than a total of six terms of service as director shall be permitted.

Article VII
Specialty sections

The House of Delegates shall provide for a division of the Society into specialty sections.

Article VIII
Meetings

Section 1. The Society shall hold an annual meeting, at which time the House of Delegates shall meet to conduct its

Adopted as amended by the House of Delegates, April 26-27, 1990.

business. The annual meeting may also include scientific sessions as determined by the Board.

Sec 2. The place for holding each annual meeting shall be fixed by the House of Delegates, or by failure to act, such authority is delegated to the Board. The time and the place for holding each annual meeting shall be approved by the Board.

Sec 3. Special meetings of the House of Delegates shall be called by the speaker on written request of twenty delegates representing at least 10% of the component county medical societies, or on request of a majority of the Board. When a special meeting is called, the speaker shall set the time and place. The secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the date of the special meeting. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall consider no business except that for which it is called.

Article IX
Officers

Officers of this Society shall be a president, a president-elect, a secretary, and a treasurer. The president-elect and treasurer shall be elected annually by the House of Delegates. The secretary shall be elected annually by the Board. The president-elect shall automatically succeed to the office of president at the conclusion of the term as president-elect. The treasurer shall be limited to nine consecutive terms. No person shall hold more than one of the following offices concurrently: president, president-elect, secretary, treasurer, speaker, vice speaker, director. Incumbents shall serve until their successors are elected and installed.

Article X
Funds and expenses

Funds may be raised by annual dues or by assessment on the members, or in any other manner approved by the House of Delegates. The House may establish regular and special classifications of membership. Dues, if any, shall be applied equitably to all members in each class. All resolutions adopted by the House of Delegates providing for appropriations shall be referred to the Board for implementation. All expenditures approved by the Board shall be included in the annual budget.

Article XI
Referendum

The House of Delegates may, by a two-thirds vote of those registered at that session, submit any question to the membership of the Society for its vote, except amendments to the Constitution. Such amendments are governed by Article XIII. The House shall determine prior to submission whether a referendum shall be advisory or binding, and so advise the membership at the time of submission. A majority vote of all the members of the Society shall determine the question on a binding referendum.

Article XII
Seal

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

Article XIII
Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual meeting, provided that such amendment shall have been introduced in the form of a constitutional amendment in open session at the previous annual meeting, and that it shall have been published at least once during the year in the Journal of this Society, or sent to each member of the Society at least two months before the meeting at which final action is to be taken.

Bylaws

Chapter 1
Membership

Section 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of the county society, shall be prima facie evidence of membership and of the right to benefits.

Sec 2. No person whose name has been dropped from the roll of members of a component society or this Society shall be entitled to any of the rights or benefits of this Society, except that such rights and benefits shall continue during the period of an appeal by such person to the Board of Directors.

Sec 3. Every physician who holds a license to practice medicine and surgery in Wisconsin shall be eligible to apply for membership. Each county society shall be the judge of the initial and continuing qualifications of its members, as well as the appropriate membership classification, subject to review and final decision by the Board of this Society. Members will conduct themselves in a manner which is not in conflict with the purposes for which the Society is organized and is operating.

Sec 4. By provision of its constitution or bylaws, a county society may require that an applicant shall have practiced within its jurisdiction for a period of one year as a condition for election to membership; or that an applicant may first be elected to membership for a term of one year only, then resubmit to election by vote of the county society without limitations as to term.

Sec 5. A member of a component society whose license has been revoked, suspended, non-renewed, or voluntarily surrendered, shall be immediately and automatically suspended from membership as of the date of revocation, suspension, non-renewal, or voluntary surrender, pending definitive action by the Board.

Sec 6. A physician's county society membership must be held in that county in which the physician's principal practice is located. However, a physician living near a county line may hold membership in that county most convenient for attending meetings, with concurrence of the component society in which the principal place of practice is maintained.

Sec 7. A member whose principal practice is moved from within the territorial limits of a component medical society to the territory of another component of the State Society shall not be eligible to continue membership in the first such society after the expiration of the calendar year in which such move shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society into whose jurisdiction the principal practice has been moved. The member shall be given a written certificate of transfer for transmission to the secretary of the society in the county to which he has moved. Pending acceptance or rejection by the society in the county to which he has moved, such member shall be considered to be in good standing in the first society and in the State Society until the end of the period for which dues have been paid.

Sec 8. When the principal practice of a member in good standing in a component society is moved outside the borders of this state, active membership in such component society and in the State Society may be continued by fulfilling all requirements of membership except residence pending acceptance as a new or transfer member by the society of the area to which the practice has been transferred. The period of such continuing membership in this state shall cease upon acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which the practice location has been transferred.

Sec 9. Membership classifications. Members defined in this section, except affiliates, shall have all the rights and privileges of the Society and shall pay dues and assessments, as indicated, as a requirement of continued membership.

A. *Regular.* Regular members of this Society consist of all the regular members in good standing of the component county societies.

B. *Special.* Included in this classification are the following categories of members who by virtue of their special circumstances are entitled to reduced dues or waiver thereof:

(1) *Part-time practice.* Any physician, regardless of age, who practices 1,000 hours or less during a calendar year, but does not qualify under section 9.B.(5), may upon application, recommendation by the county medical society, and approval by this Society, be placed in this special category.

(2) *Resident.* Physicians in approved training programs as hospital residents or as research fellows who are licensed to practice medicine and surgery in Wisconsin. Such special membership category can be maintained for a maximum of five (5) consecutive years.

(3) *Temporary Military Service.* Members who are inducted into the United States Military or Public Health Service and serve in such capacity for not more than five (5) years.

(4) *Associate.* Members who suffer a disability preventing them from practicing medicine with resulting serious financial reverses which would make the payment of dues a matter of personal hardship. Such membership shall be on an annual basis, upon recommendation of the county society and approval by the Board of this Society.

(5) *Retired.* Members who have retired completely from the practice of medicine, or who practice 240 hours or less during a calendar year, upon recommendation of the county society and approval by this Society.

(6) *Life.* Those members of the State Medical Society of Wisconsin who have been members of this or other state medical societies for fifty (50) years, or are past presidents of the State Medical Society of Wisconsin. They shall receive a certificate of Life Membership.

(7) *Honorary.* Members who have been elected to a similar classification by their county society because of outstanding contributions to the medical profession, upon approval by the Board of this Society.

(8) *Over Age 70.* Members who are age 70 effective January 1 of the following year.

C. *Affiliate.* Persons who are not otherwise eligible for membership may become affiliated with this Society in one of the following categories. Their dues or assessments, as well as rights and privileges as affiliate members, shall be determined by the Board.

(1) *Candidate.* Upon application, a county medical society or this Society may confer upon any person then attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure the status of Candidate Member.

(2) *Scientific Fellow.* The Board may by invitation and unanimous consent confer upon any person engaged in teaching of or research in one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

(3) *Emeritus.* Retired members who have chosen not to renew their license, at the discretion of the Board.

Sec 10. Dues and Assessments. Members shall pay dues and assessments as follows:

A. *Regular members:* full dues and assessments.

B. *Physicians in part-time practice or over age 70:* one-half of regular member dues and assessments.

C. *Physicians in residency or fellowship training:* dues and assessments are to be determined by the Board of Directors. Dues and assessments for all other categories shall be waived, except as may be determined by the Board for affiliate members.

Chapter II
House of Delegates

Section 1. Each component county society shall be entitled to send one delegate and one alternate to the House of Delegates for each forty regular and special members or majority fraction thereof in this Society, provided, however, that each county society shall be entitled to at least one delegate and one alternate from that county society. For purposes of this section, the number of members as of the close of the calendar year preceding the first session of the House of Delegates at the Annual Meeting shall determine the number of delegates to which a county society shall be entitled. The secretary of each county society will send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve.

Sec 2. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

Sec 3. The speaker shall preside at the meetings of the House of Delegates.

Sec 4. The vice speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice speaker shall officiate during the unexpired term.

Sec 5. The speaker shall appoint members of reference committees from among the members of the House of Delegates. These committees shall consider and make recommendations to the House relative to resolutions, reports of officers, reports of commissions and committees, financial and other matters germane to the business of the House. The speaker shall also appoint a credentials committee and such other committees as deemed necessary.

Sec 6. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Sec 7. The House of Delegates shall have authority to create committees for special purposes and to appoint members of the Society who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and their members may be present to participate in the debate on their reports.

Sec 8. It shall receive for appropriate action the annual reports of the treasurer, secretary, and chairman of the Board of Directors.

Sec 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society two months before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Board of Directors or any member thereof, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

Sec 10. All questions of an ethical nature brought before the House of Delegates shall be referred to the Board of Directors without discussion.

Chapter III
Annual election

Section 1. The House of Delegates, at its first session of the annual meeting, shall elect a Committee on Nominations consisting of one (1) delegate for each district, except that in any district having five hundred (500) or more regular and special members, there shall be elected one (1) additional delegate for each additional five hundred (500) members or majority fraction thereof. One (1) delegate representing the specialty sections shall also be appointed. Nominating committee members shall be limited to nine (9) consecutive terms. Those committee members who have served nine (9) consecutive terms upon adjournment of the final session of the 1993 House of Delegates annual meeting and following years shall have met this requirement. This committee shall become operative at the close of the final session of that annual meeting and shall function until the close of the final session of the following year's Annual Meeting. The incoming committee shall meet with the existent committee but without vote during the overlapping days of the annual meeting. Any vacancy occurring in the Committee on Nominations between the date of its formation and the time of its reporting shall be filled by appointment by the director or directors of the district in which the vacancy occurs, provided that if the vacancy occurs in the representation from the specialty sections, such vacancy shall be filled by ballot from among the section delegates. The Committee on Nominations shall convene at least two (2) months prior to the annual meeting of the House of Delegates to prepare a slate of candidates. This meeting, to be held at a time, date and location published to the general membership at least two (2) months before this meeting, shall include an open session of not less than one (1) hour to allow individual nomination of candidates. The Committee shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the positions to be filled.

Sec 2. The report of the Committee on Nominations and elections shall be the first order of business of the House of Delegates at the third session of the annual meeting.

Sec 3. The House of Delegates shall elect the president-elect, the treasurer, the speaker and vice speaker of the House of Delegates, and the delegates and alternates to the American Medical Association. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by separate ballot for each individual position, and a majority of the votes cast shall be necessary to elect. If no nominee receives a majority of the votes on the first ballot, the nominee

receiving the lowest number of votes shall be dropped, except where there is a tie, and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the votes cast.

Sec 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

Chapter IV
Duties of officers

Section 1. The president is the chief constitutional officer of the Society. Within the limits of the Constitution, Bylaws, and policies of the House of Delegates and Board of Directors, the president shall have the following responsibilities and commensurate authority:

a. deliver an annual address to the House;
b. serve as a member with right to vote on the Board;
c. preside at meetings of the Executive Committee of the Board;
d. participate, ex officio and without the right to vote, in sessions of the House;
e. initiate and propose policies and programs that will further the goals and objectives of the Society for consideration by the House, Board, commissions and committees;
f. support and articulate policies and programs adopted by the Board and the House.
g. promote physician interest and active participation in the Society.

Sec 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant, the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect, the Board shall appoint one of its members as acting president until the next meeting of the House of Delegates.

Sec 3. The treasurer shall be responsible to the Board of Directors, and shall advise and assist it in making decisions on investment policy and financial matters. The duties of the treasurer shall include the following:

a. Be responsible for all funds due the Society, together with bequests and donations;
b. Pay money out of the treasury only on written order of the secretary;
c. Subject the treasurer's accounts to such examination as the House of Delegates may order;
d. Annually report on the financial standing of the Society, including a balance sheet and income and expense report;
e. Give bond in such amount as the Board may provide.

Sec 4. The Secretary is the chief executive officer of the Society charged with the execution of policy as created and defined by the House of Delegates and the Board of Directors. The Secretary shall serve as an ex officio, nonvoting member of the Board; be responsible to the Board and serve as its secretary; assist the Board and officers in making decisions and implementing actions; share convictions and argue their merits; perform the functions ordinarily assigned to the office of Secretary, and make an annual report to the House of Delegates. "As chief executive officer the secretary shall, within the limits of the Constitution and Bylaws and Board operating policies, effectively perform the general managerial function for the Society and all of its divisions, activities, and personnel including employment and, as necessary, termination of all employees; be responsible for and have the necessary authority to direct, supervise, and coordinate all programs, projects and major activities of the Society and all wholly owned subsidiaries; formulate and recommend for approval of the Board basic policies and programs which will seek to achieve the objectives and goals of the Society; fully inform the Board on the condition and operation of the association; cooperate with the Board and Treasurer in establishing a program of fiscal responsibility for the Society including development, recommendation and upon approval, operation within an annual budget; act to insure that all funds, physical assets, and other property of the Society are appropriately safeguarded and administered; develop and maintain effective internal and external communications with the membership and other organizations and agencies, both public and private, so as to enhance the positions of the Society and the objectives of its membership; and through effective management and leadership, achieve economic, productive performance, forward-looking programming, and constructive growth of the Society."

Note: Following adoption of this Bylaw change (Sec. 4 above) in 1987, the Board agreed to develop and maintain a set of current "operating policies" between itself and the secretary to detail the more specific duties and expectations important to a good working relationship between the Board and the secretary.

Chapter V
Board of Directors

Section 1. The Board of Directors shall be the executive body of the Society. Between meetings of the House of Delegates it shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

Sec 2. The Board shall meet during the annual meeting and at such other times as necessity may require, subject to the call of the chairman or on petition of three directors. It shall hold an annual meeting for purposes of organization and other business.

Sec 3. The Board shall elect a chairman and a vice chairman from among its voting members. It may create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities. Its chairman shall submit an annual report to the House of Delegates including all major actions and policy

decisions of the preceding year.

Sec 4. Each director shall be the organizer and mediator for the district. Directors shall visit each county in their district as needed for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep informed of the activities of the component societies in the district. Each director shall arrange for an annual conference or caucus with the societies or their delegates within the district, at which time information shall be disseminated concerning the activities of the State Medical Society and component societies within the district. Each director shall report as necessary to the Board. The necessary traveling expenses incurred by each director in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include the expense of attending the annual meeting of the Society.

Sec 5. The Board of Directors shall be the judicial body of the Society. It may decide any questions of conduct or discipline of members, or any questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. It shall develop and publish procedures for discipline, including denial of initial or continuing membership, for those physicians who fail to provide quality health care, failure to pay dues, loss of license to practice, or other cause. Its decisions in all cases shall be final, including the right to expel a member should a component society fail to do so after being so requested by the Board. The Board's right to original jurisdiction includes but is not limited to the right to decide cases when:

a. the affected parties reside within the boundaries of a single county medical society and that society does not wish to assume jurisdiction;
b. the affected parties reside in two or more component medical society jurisdictions. The Board also has within its authority the right to appoint a commission or commissions to which any or all such matters may be referred for investigation, evaluation and decision to acquit, admonish, or otherwise discipline as appropriate. A member may appeal to the Board the decision of such commission or the action of a county society as provided in Chapter X, Section 3. If the recommendation is for suspension or expulsion of a physician from Society membership, final action must be taken by the Board.

Sec 6. Charters shall be issued to county societies only on approval of the Board, with ratification by the House of Delegates, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Board, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Sec 7. In sparsely settled sections, the Board shall have authority to organize the physicians of two or more counties into societies. These societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Sec 8. The Board shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have the authority to appoint an editor of the Journal and such assistants as it deems necessary.

Sec 9. The Board shall select a qualified independent accounting firm and receive an annual audit of all accounts of this Society. With the treasurer, it shall supervise the investment of funds. The Board shall adopt an annual budget providing for the necessary expenses of the Society.

Sec 10. The Board may, by interim appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates. The appointee shall serve until a successor has been elected and has qualified. When a district initially qualified for an additional director, such position shall be considered new and not a vacancy to which the Board is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article VI of the Constitution. The initial term shall be so established as to maintain the election of substantially one-third of the directors each year.

Sec 11. The Board may elect as secretary one who need not be a physician or a member of the Society.

Sec 12. The Board shall provide such facilities for the Society as may be required to properly conduct its business.

Chapter VI
Commissions and committees

Section 1. The Board shall appoint such commissions and committees, either permanent or ad hoc, as it deems necessary to properly conduct the affairs of the Society. Membership on such committees and commissions shall be limited to members of the Society and its Auxiliary. Nonmembers of the Society or its Auxiliary may be appointed as special representatives should their expertise and knowledge be of benefit to the goals of such commissions or committees. Such individuals shall not have the right to vote or hold office. Each commission and committee shall have the duty of being informed on matters within the area of its special interest. They shall represent the Society's interests by continual contacts with voluntary and governmental agencies having related concerns with the intention of coordinating efforts to serve the health interests of the people of Wisconsin. They shall develop recommendations from their studies and activities for action by the Board or House of Delegates.

Sec 2. Specialty sections shall be regarded as special committees of the Society from which the Board or any commission or committee may seek advice and assistance on matters of special or general concern to the profession and the health

of the people of Wisconsin. The specialty sections will be expected to give special requests prompt consideration and response so as to enable the Society to make maximum use of their resources.

Chapter VII
Dues and assessments

Section 1. The annual dues and assessments of this Society shall be determined by the House of Delegates and shall be levied per capita on the members. Dues and assessments shall be payable as determined by the Board of Directors. Any member whose current year's dues have not been received by the secretary on or before the dues payment deadline, as established by the Board of Directors, shall be deemed in arrears and shall be removed from the membership rolls of the county society and this Society until such time as full dues for the current year have been received.

Sec 2. The record of payment of dues and assessments on file in the offices of this Society shall be final as to the fact of payment by a member and to the right to participate in the business and proceedings of the Society or the House of Delegates and to any other benefits and privileges of membership.

Chapter VIII

The Board of Directors shall adopt ethical guidelines for the members of this Society.

Comment: On July 18, 1981 the Board of Directors adopted the Principles of Medical Ethics of the AMA as the ethical guidelines of the Society.

Chapter IX

The current edition of Sturgis Standard Code of Parliamentary Procedure governs this organization in all parliamentary situations that are not provided for in the law or in its charter, constitution, bylaws, or adopted rules.

Chapter X
County societies

Section 1. All present county societies or those that may hereafter be organized in this state shall, upon application to the Board of Directors, receive charters from this Society, provided that their constitutions and bylaws have been submitted to the Board and found in conformity with the Constitution and Bylaws of the State Medical Society. All revisions shall be submitted to the Society, approved by the Board, and filed with the secretary. Where a county society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Board, shall be deemed to apply.

Sec 2. Only one component medical society shall be chartered in each county.

Sec 3. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Board of Directors of the State Society. Its decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Board of the State Society for final determination. The mechanisms and procedures which apply to the appeal process shall be those adopted by the Board.

Sec 4. Each component county society shall elect one or more delegates and may elect an equal number of alternates to substitute for any absent delegates from that component society, for a term of two calendar years, to represent it in the House of Delegates of this Society, in accordance with Chapter II, Section 1, of these Bylaws. The term of office shall begin on January 1 of the year succeeding the election of such delegates and alternates.

Sec 5. The secretary of each county society shall keep a roster of its members.

Chapter XI
Specialty sections

Section 1. The House of Delegates shall establish specialty and special sections within the Society. It shall have the power to combine, enlarge, or discontinue any or all of such sections so established using the following guidelines:

a. For specialty section to be designated it must represent a specialty which is represented in the American Medical Association House of Delegates and
b. Have at least twenty (20) members of the specialty who are members of this Society.
c. If no representative from the specialty section registers as a representative of that section for three (3) consecutive annual meetings, the specialty section will be dropped with the option of reapplying after one year, provided the above criteria are met.
d. From time to time special sections not meeting the above criteria may be established by the House of Delegates.

Sec 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest. Qualifications for membership in any section shall be established by the members of such section, subject to approval of the Board of Directors, Scientific meetings of a section shall be open to all members in good standing of the State Medical Society.

Sec 3. The officers of each section shall be elected by and from its membership. The terms of such officers shall be for one year, but any officer may be reelected.

Sec 4. No section shall have the power to bind the State Medical Society by any resolution or other action. No such resolution or action shall be publicized unless it shall first have been approved by the House of Delegates, or by a majority of the Board when the House is not in session. No resolution adopted by any section shall be effective until likewise so approved.

Sec 5. Each section shall elect a delegate and an alternate to the House of Delegates. The term shall be for two calendar years without limitation on number of terms.

Sec 6. The specialty sections of the Society shall be considered an integral part of the working committee structure of the Society as outlined in Chapter VI of these Bylaws.

Chapter XII
Amendments

These Bylaws may be amended at any annual meeting by a majority vote of the delegates present, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one session of that annual meeting.[150th]

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Key: president (P), president elect (PE), vice president (VP), secretary (S), treasurer (T), secretary-treasurer (ST), executive secretary (ES), executive vice president (EVP), executive director (ED). As of 6/1/92

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Wisconsin Chapter: American College of Emergency Physicians
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VP–Timothy J Hill, MD
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Cedarburg 53012
S–Wendy A Witt, MD
995 Brighton Dr
Menasha 54952
T–Terry Geurkink, MD
1675 Bartlett Ct
Belleville 53508
ED–Karen Teske-Osborne, MSN
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Madison 53715-0282
608-277-9110

Wisconsin Academy of Family Physicians
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PE– Alan D Strobusch, MD
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ST–Lowell H Keppel, MD
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Milwaukee 53207
414-744-4304
ES–Robert H Herzog
850 Elm Grove Rd
Elm Grove 53122
414-784-3656

Wisconsin Society of Internal Medicine
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715-387-5345
ST–Bruce A Polender, MD
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608-782-7300
ED–Sandy Koehler
611 E Wells St
Milwaukee 53202
414-276-6445
Fax-414-276-3349

Wisconsin Neurological Society
P–Thomas Zweifel, DO
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414-457-3737
PE–Gary Leo, MD
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Milwaukee 53211-4565
414-225-8032
VP–Stephen Somerville, MD
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414-436-7100
ST–Kevin Ruggles, MD
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Marshfield 54449
715-387-5351

Wisconsin Neurosurgical Society
P–Robert A Narotzky, MD
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PO Box 1510
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715-839-5270
PE–Mohammed Rafiullah, MD
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Racine 53403
ST–Wade Mueller, MD
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Wisconsin Society of Obstetrics and Gynecology
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PE–Robert J Jaeger, MD
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ST–Everett A Beguin, MD
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Madison 53703
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STE–Paul S Treuhaft, MD
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Marshfield 54449

Wisconsin Society of Otolaryngology-Head and Neck Surgery
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608-782-7300

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414-554-2285

Continued on next page

Continued from preceding page
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S–Magbool Arshad, MD
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T–Saleem Bakhtiar, MD
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414-673-5050

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Madison 53713
ST–Karen Wendelberger, MD
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Milwaukee 53201
CA–Beth A Johnson
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S–Nina Vicente, MD
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Milwaukee 53233
414-342-9800
S–Violeta A Singson, MD
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Milwaukee 53233
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T–Romeo C Lo, MD
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E3/350 CSC
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608-263-8649
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Milwaukee 53226
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ST–Ephrem Thoppil, MD
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Milwaukee 53201-2901
414-649-7706

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Beloit 53511
608-364-2240
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Marshfield 54449-5777
715-387-5435

Wisconsin Society of Plastic Surgeons
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Milwaukee 53211
414-271-8283
VP–Venkat Rao, MD
600 Highland Ave
Madison 53792
ST–Andreas Doermahn, MD
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Milwaukee 53211
414-963-1700

Wisconsin Society for Preventive Medicine
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608-266-1253
ST–Constantine Panagis, MD
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715-834-2751
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T–Kenneth I Robbins, MD
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ES–Edward S Levin, Esq
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Madison 53701
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Wisconsin Council of Child and Adolescent Psychiatry
P–William J Swift, Jr, MD
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Madison 53792
608-263-6099
T–Mary Pearlman, MD
236 Lakewood Blvd
Madison 53704
S–Edward S Orman, MD
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Wisconsin Surgical Society
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414-338-1123
PE–William O Myers, MD
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Marshfield 54449
ST–Barry J Seidel, MD
9601 Townline Rd
Minocqua 54548
715-358-1000

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Waukesha 53186
414-542-0444

Richard G. Roberts, MD, JD, presides over the 1992 SMS House of Delegates as speaker of the House. William Listwan, MD, president, is left; Kenneth Gold, MD, vice speaker, is right.

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608-263-9534
ST-Frank P Begun, MD
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child·reach

(chīld-rēch) *n.* 1. *Formerly Foster Parents Plan, the largest non-sectarian sponsorship organization in the world. Founded in 1937 to help needy children and their families overseas.* 2. *A way to reach a child and family and release them from the crushing grip of poverty.* 3. *A wonderful thing to do.* 4. *An easy thing to do.*

The above definitions do not come from a dictionary. They come from the heart. Call 1-800-323-2822. Childreach. It'll do *your* heart good!

childreach

Statewide Physician Health Program

The Statewide Physician Health Program functions under the purview of the Commission on Mediation and Peer Review, although its activities are managed by a seven-member managing committee. The program protocol guides the general handling of inquiries or concerns regarding identified impaired physicians. Available to Wisconsin licensed physicians, the program offers education, identification, assessment, and compassionate intervention. The program refers patients to acceptable facilities for evaluation or treatment, and monitors a two-year follow-up after completion of initial therapy. Through its efforts, a number of physicians have been encouraged by compassionate colleagues to enter structured rehabilitation.

Literature on the subject contends that from 10% to 14% of practicing physicians have difficulty with alcohol and drugs. Some research suggests that, during a lifetime, one in ten physicians will abuse alcohol in professional circumstances, so as to be identified as impaired.

Unfortunately, many people in a position to observe and identify impaired physicians do not know what to do when they perceive a problem, nor do they realize that help is available from organized programs. Furthermore, individuals such as medical staff members, hospital administrators, and others are reluctant to report a physician to an organized program. Their initial reaction is to not get involved, or to conclude that the problem can be handled by someone else in some other manner. This attitude often results in delayed intervention and treatment, or in passive action which ultimately fails. Others, who might otherwise report an impaired physician may seek legal advice, only to be told by lawyers to be noncommittal and to respond only to a subpoena. Such advice could be a deterrent to early intervention.

Current techniques of identification, intervention, assessment, treatment, and follow-up of impaired physicians are not well known in the medical community. Physicians are not generally adequately trained or skilled in identification, diagnosis, and treatment of patients with chemical dependency. As a result, few are able to respond adequately when they accept an impaired physician as a patient.

Through efforts of the Managing Committee, the SMS Board of Directors approved the concept of contracting with a part-time medical director to provide continuous program leadership and activity. The SMS House of Delegates adopted the Board's recommendation and approved a $15 dues increase to fund the position.

Phase I: Education and prevention

Target individuals and groups are educated to understand physician chemical dependency. They learn symptoms of impairment; techniques of early identification and prevention; and resources available for identification, assessment, intervention, and treatment; and social, financial, legal and other problems associated with impairment.

Primary target groups.

- Physicians: Meetings of hospital medical staffs, county medical societies, regional or statewide continuing medical education, and accredited seminars, (eg., at the SMS Annual Meeting).
- Hospital Personnel: Hospital administrators and medical directors, chiefs of medical staffs, hospital boards of trustees, directors of nursing and pharmacy, and others (eg, anesthetists and technicians). Consultation for medical staff officers on establishing effective impaired physician committees or programs in hospitals. "Guidelines for Physician Aid Committees of Hospital Medical Staffs" have been distributed to all Wisconsin general hospitals with encouragement to implement them in cooperation with medical staffs. Copies of guidelines are available upon request.
- Pharmacists, Nurses, and Nursing Home Administrators: Lectures at association meetings, or in combination with physician and hospital personnel meetings.
- Spouses and Families of Physicians: Educational material available at state and county medical society and auxiliary meetings.
- Legal Profession: Urge lawyers, whose state association has its own impaired lawyers program, to encourage their physician clients to use organized medicine's voluntary impaired physicians programs, when perceived needs arise.
- Teaching staff. Teaching staff presents educational and prevention programs to the various target groups.

Literature is available to assist in an understanding of the disease of chemical dependency, and to explain intervention, treatment and follow-up resources.

Phase II: Intervention and treatment

Successful programs include the availability of physician interveners to perform compassionate colleague-to-colleague contact with physicians identified as impaired.

Approximately 35 trained physicians throughout Wisconsin are available to meet with and urge impaired colleagues to leave the medical practice to enter suitable programs for evaluation and treatment. Programs considered suitable are those which comply with Statewide Physician Health Program requirements.

Interveners act as teams. At least one intervener is either expert in or recovering from the impairment of concern. The initial intervention is always a compassionate encounter. The Wisconsin program has no interest in the punitive or coercive approach until all benevolent measures have been exhausted. An intervener's interests are the personal well-being of a colleague, and the quality of health care for patients.

The Statewide Physician Health Program has learned that physicians achieve a more satisfactory recovery status when they receive intensive treatment for chemical dependency in facilities which espouse the medical model of therapy, under which the physician is seen by the physician addiction specialist on a frequent, if not daily basis. Within this model, the Program has established certain requirements for satisfactory primary treatment of chemical dependency.

Physicians suffering from emotional illness or senility, or from the sequelae of stress when these are uncomplicated by chemical dependency, will be encouraged to seek assessment and/or treatment through Statewide Program approved facilities or practitioners.

The Program adheres to the policy that satisfactory recovery from chemical dependency can only be realized through a monitored two-year recovery period. It considers the two-year after hospitalization component to be vital to assuring continued recovery.

Phase III: Benevolent assistance

In addition to the burdens of impairment, some physicians are financially unable to pay the cost of in-patient care. By estimate, at least 10% of Wisconsin impaired physicians have either no or inadequate health insurance. Some have been ill for so long that their financial resources essentially have been depleted. About 10% of the charges for rehabilitation of such physicians go unpaid. For 20% of impaired physicians, residence and treatment in recovery homes (average of three months stay, at a cost of $1,900 per month) is essential for completion of the two-year recovery program.

With approval of the SMS and CES Foundation Board of Directors, the Statewide Physician Health Program established a Physicians Benevolent Assistance Fund with pledges to the CES Foundation. The fund appeal among SMS members and Wisconsin hospitals was designed to develop a fund of $150,000 for low-interest loans to impaired physicians, who can potentially repay the loan(s) after returning to medical practice.[15,16]

Mediation and peer review services

When misunderstandings arise about what the physician hopes to accomplish and what the patient expects it is important that the patient discuss with the physician any questions about the medical care received. If they are not resolved, however, the SMS provides a means for resolving these differences.

The SMS Commission on Mediation and Peer Review receives, investigates, and resolves complaints and inquiries from patients and others, concerning Wisconsin physicians. The commission's standard of judgment is what constitutes good medical care. Physicians, too, may benefit from commission efforts to mediate differences between themselves.

Many complaints and questions received by SMS staff are resolved by telephone. By protocol, however, only written complaints will be considered by the commission. If all affected parties reside within the boundaries of a single county medical society, that society may assume jurisdiction of the complaint. If it does, the complaint will be transferred to the county medical society for investigation and resolution.

A protocol manual was developed by the Commission on Mediation and Peer Review and approved by the Board of Directors for conducting resolution of patient complaints, employing peer review mechanisms to test physician practice patterns, and responding to inquiries or requests for action regarding impaired physicians. The manual was designed to accommodate informal disposition of minor and uncomplicated complaints, as well as complex and serious matters which may involve due process, patient or physician appeals, proposed disciplinary actions, and Board of Directors consideration of a physician's SMS membership. The manual is available upon request.

Certain complaints received by the commission are evaluated by subcommittees, members of which submit reports and recommended resolutions to the commission chair. Frequently, these subcommittee conclusions are transmitted to the subject physicians, and as appropriate, to complainants. All subcommittee activities are reported to the commission. Matters of a more serious nature require additional use of the manual, as necessary.

The Commission on Mediation and Peer Review offers peer review services to private and governmental organizations and to physicians, including utilization review, appropriateness of patient care, and quality assurance. Although it is empowered to initiate disciplinary action, the commission's most valuable peer review benefits have been educational, judging from physician's expressed appreciation for the commission's consultation in matters of proper patient care.

The commission maintains purview over the Statewide Physician Health Program and continues its interest in the Coordinating Council on Physician Impairment of the SMS and the Medical Examining Board. The commission participates in the Medicaid Medical Audit Committee, under contract between the SMS and the Wisconsin Department of Health and Social Services.

Commission members will also review cases submitted by physicians who are the subject of Medicare or Medicaid reviews, to provide an independent assessment of the appropriateness of care provided. In those instances where the commission disagrees with a WIPRO or other review organization finding, the commission will provide the physician with independent medical opinion in any further action taken by the review agencies.[15,16]

SMS physicians' support group

THE SMS MEDICAL Liability Committee in 1987 created the Physicians' Support Program to help physicians and their families cope with the stress of being sued for malpractice. The program provides emotional support, practical information, and an opportunity for the physician and spouse to share their feelings with sympathetic listeners.

How the program works

When a physician is sued for medical malpractice, the SMS sends him or her a packet of materials that includes a letter explaining the Physicians' Support Program, advice on coping with the experience, and a list of physicians and spouses who have volunteered to serve as members of a special support group. The packet also contains a description of the Medical Mediation Panel System and helpful materials for the physician's spouse.

The Physician's support group

The purpose of the support group is to offer emotional support and practical advice for dealing with a medical malpractice suit. The emphasis is on personal contact and communication between the physician or spouse requesting help and the panel member. The setting of meetings is left entirely to the parties involved, and may be limited to telephone calls, if so desired. Topics covered during meetings are expected to be wide ranging, (eg feelings of hostility, fear, loss of confidence, difficulty in making decisions, and withdrawal from the family) but discussions of the specific merits of the case are avoided. The emphasis is on individual interaction and open and frank discussions. There are no group sessions. Confidentiality is assured in all cases.

Any practicing physician who has been a respondent in a malpractice action and feels he or she can offer emotional support to a colleague in a similar situation is encouraged to volunteer as a support group member. Spouses who can provide support for their counterparts are also invited to participate. Each panelist receives basic information about the program and advice on how to be an effective participant.

Physicians interested in participating in the Physicians' Support Group should contact Cecilia Geis in the Division of Medical Policy and Practice at the SMS.

Letter to physician named in a medical mediation case

Items mentioned in this letter as "enclosed" are available from the Division of Medical Policy and Practice at SMS.

Dear Doctor:

According to our records, you have been named in a medical mediation case. Feelings such as anger, frustration and depression are common for physicians involved in a malpractice action. I am writing this letter to inform you that there are other physicians and spouses who have been through similar experiences and are willing to discuss those feelings.

As part of the work of the Medical Liability Committee, we have looked at the effect of the medical malpractice action on the physician and his/her family. It was the recommendation of the Medical Liability Committee to the Board of Directors that the State Medical Society establish a support structure for physicians and their families involved in medical malpractice actions. Part of our proposal recommended the establishment of a group of physicians and spouses who could serve as "sympathetic listeners" for the physicians and their families involved in a liability action.

I invite you and your spouse or significant other to use the program. The SMS Auxiliary strongly supported the creation of the support group, because it would be very beneficial to family members. Enclosed is a list of physicians and spouses who have volunteered to serve. Please feel free to contact any physician or spouse on the list. He or she will assure you of maintaining confidentiality.

Also, enclosed is a brief description of the program for you and your spouse and helpful materials to cope with the stress associated with medical litigation. Remember, talking to an experienced, knowledgeable peer about your frustrations is important. If you have further questions about the program or would like additional information, please feel free to contact Cecilia Geis at SMS, 1-800-362-9080.

Sincerely,

Thomas M. Kidder, MD
Chair, Medical Liability Committee

Accreditation program for continuing medical education

The SMS's accreditation program functions under the authority of the AMA's Accreditation Council for Continuing Medical Education (ACCME). Representatives from state medical societies, national medical specialty societies, the AMA Section on Medical Schools and Resident Physician's Section, the National Medical Association, the American Hospital Association, the Association for Hospital Medical Education, the Federation of State Medical Boards, and medical specialty boards comprise the ACCME.

The SMS Commission on Continuing Medical Education currently reviews and accredits 54 hospitals, 22 specialty societies, two professional organizations, and one county medical society in Wisconsin. Information is available from Kristin Bjurstrom Krueger or Lisa Lawry at the SMS.

Category 1
CME activities with accredited sponsorship. Education activities that are a part of a planned program of continuing medical education and sponsored by an accredited organization.

Category 2
CME activities with an accredited or non-accredited organization.

- CME lectures and seminars not designated as Category I by an accredited sponsor;
- medical teaching;
- articles, publications, books, and exhibits;
- non-supervised individual CME, including self-instruction, consulta-tion, patient care review, and self assessment; and
- other meritorious learning experiences.

The following Wisconsin organizations were accredited by SMSW and ACCME for continuing medical education programming as of June 1, 1992:

Accredited hospitals

Appleton Memorial and St Elizabeth Hospitals, Appleton
Bellin Memorial Hospital, Green Bay
Beloit Memorial Hospital, Beloit
Berlin Memorial Hospital, Berlin
Columbia Hospital, Milwaukee
Community Memorial Hospital, Menomonee Falls
Fort Atkinson Memorial Hospital, Fort Atkinson
Gundersen Medical Foundation, Ltd and La Crosse Lutheran Hospital, La Crosse
Hartford Memorial Hospital, Hartford
Howard Young Medical Center, Woodruff
Kenosha Memorial Hospital, Kenosha
Lakeland Hospital, Elkhorn
Langlade County Memorial Hospital, Antigo
Luther Hospital, Eau Claire
Memorial Hospital of Iowa County, Dodgeville
Memorial Hospital at Oconomowoc, Oconomowoc
Mendota Mental Health Institution, Madison
Mercy Hospital, Janesville
Mercy Medical Center, Oshkosh
Meriter Hospital, Madison
Reedsburg Memorial Hospital, Reedsburg
Riverside Community Hospital, Waupaca
Sacred Heart Hospital, Eau Claire
Sacred Heart-St Mary's Hospital, Inc, Rhinelander
Sauk Prairie Memorial Hospital, Prairie du Sac
Shawano Community Hospital, Shawano
Sheboygan Memorial-St Nicholas Hospitals, Sheboygan
Sinai Samaritan Medical Center, Milwaukee
St Agnes Hospital, Fond du Lac
St Anthony's Family Medical Center, Milwaukee
St Catherine's Hospital, Kenosha
St Clare Hospital, Baraboo
St Clare Hospital, Monroe
St Francis Medical Center, La Crosse
St Francis Hospital, Milwaukee
St Joseph's Hospital, Chippewa Falls
St Joseph's Hospital & Marshfield Clinic, Marshfield
St Joseph's Hospital, Milwaukee
St Joseph's Community Hospital, West Bend
St Luke's Hospital, Milwaukee
St Mary's Hospital Medical Center, Madison
St Mary's Hospital, Milwaukee
St Mary's Hospital-Ozaukee, Port Washington
St Michael Hospital, Milwaukee
St Michael's Hospital, Stevens Point

Continued on next page

Benjamin Wedro, MD, of La Crosse addresses the SMS House of Delegates.

Continued from preceding page
St Vincent Hospital, Green Bay
Stoughton Hospital Association, Stoughton
Theda Clark Regional Medical Center, Neenah
Trinity Memorial Hospital, Cudahy
Veterans Administration Medical Center, Tomah
Watertown Memorial Hospital, Watertown
Waukesha Memorial Hospital, Waukesha
Wausau Hospital Center, Wausau
West Allis Memorial Hospital, West Allis
Winnebago Mental Health Institute, Winnebago

Accredited specialties
American Cancer Society, Wisconsin Affiliate, Madison
American Heart Association of Wisconsin, Milwaukee
Arthritis Foundation, Wisconsin Chapter
Blount and Schmidt Spinal Study Group
Fox Valley Academy of Medicine
Milwaukee Gynecological Society
Milwaukee Ophthalmological Society
Milwaukee Orthopaedic Society
Racine Academy of Medicine
Wisconsin Academy of Family Physicians
Wisconsin Academy of Ophthalmology
Wisconsin Allergy Society
Wisconsin Association for Perinatal Care
Wisconsin Neurological Society
Wisconsin Psychiatric Association
Wisconsin Surgical Society
Wisconsin Society of Obstetrics and Gynecology
Wisconsin Society of Otolaryngology–Head and Neck Surgery
Wisconsin Society of Pathologists
Wisconsin Society of Plastic Surgeons
Wisconsin Society of Radiation Oncologists
Wisconsin Urological Society

Accredited county medical societies
Marinette-Florence County Medical Society

Other accredited organizations
Physicians Insurance Company of Wisconsin
Wisconsin Association of Medical Directors

ACCME accredited
Medical College of Wisconsin
UW Center for Health Sciences
Interstate Postgraduate Medical Association
State Medical Society of Wisconsin
Wisconsin Society of Anesthesiologists

Membership facts

WHETHER YOU ARE JUST STARTING medical school, engaged in postgraduate training, maintaining a full-time practice, or retired, the SMS has a membership classification to fit your needs. Election to membership by the county medical society in which your principal place of practice is located carries with it membership in the SMS and, if you wish, the American Medical Association. If you qualify for resident membership at the time of your election, your membership dues are greatly reduced. You may also qualify for reduced dues during the first two years of your practice. In addition, two-physician families may be eligible for a $50 discount on total SMS membership dues. Regular membership dues in 1992 are $595 for the SMS and $400 for the AMA; county society dues vary.

Dues for regular, part-time practice, or over-age-70 membership classifications may be paid in one lump sum or in two equal installments, with the first half due by Oct 1, 1991, and the second half by Jan 1, 1992.

An incentive plan is available for early payment of county and state dues: 5% off state dues for those who pay state and county dues in full by Oct 1, 1991.

A more detailed list of SMS membership classifications and their corresponding dues follow.

SMS Membership classifications

Regular: Member in active practice. Regular members who are in their first or second year out of residency, fellowship, or military obligation may qualify for reduced dues for the SMS, the AMA, or both.

Part-time practice: Physician regardless of age who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Resident: Member who as of Jan 1 of the dues year is in an approved training program as a hospital resident or research fellow and is licensed to practice medicine and surgery in Wisconsin.

Military service: Member who is serving in the US armed forces or US Public Health Service (generally not to exceed 5 years).

Associate: Member whose dues are waived because of financial hardship due to illness or disability. This classification is temporary and is reviewed on an annual basis.

Retired: Member who has completely retired from practice (works less than 240 hours each year). All dues are waived

unless county society indicates it wishes to charge county dues. (Retired and life members who wish to receive *Medigram* and the *Wisconsin Medical Journal* must pay a $45 publications fee.)

Life: Member who has held membership in a state medical society for 50 years. Past presidents of the SMS are also included in this category.

Honorary: Physician named an honorary member by the Board of Directors for outstanding contributions to the medical profession.

Over age 70: Member in active practice who is over 70 years of age.

Scientific fellow: Person engaged in teaching or research in the basic sciences at an accredited college or university–but not holding a degree in medicine or osteopathy–by invitation and consent of the Board of Directors.

Emeritus: Retired member who has chosen not to renew his or her license.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

1992 Dues

	SMS	*AMA*	*County*
Regular	$595	$400	Normal county dues
First year in practice	$297	$200	Normal county dues
Second year in practice	$446	$300	Normal county dues
Two physician family	$545	$400	Normal county dues
Part-time practice	$297	$400	Normal county dues
Part-time over age 70	$297	$200*	Normal county dues
Resident	$ 70	$ 45	Varies
Military service	-0-	$264/$45	-0-
Associate	-0-	-0-	-0-
Retired	-0-	$400/$80/-0-*	-0-
Retired, over age 70	-0-	-0-	-0-
Life -0-	$400/-0-*	-0-	
Honorary	-0-	$400/-0-*	-0-
Over age 70	$297	$400/-0-*	Normal county dues
Scientific Fellow	-0-	-0-	-0-
Emeritus	-0-	-0-	-0-
Candidate:			
Student	$ 20[1]	$ 20[2]	-0-
Postgraduate-one	$ 10	$ 45	Varies

[1]students' SMS and county dues for four academic years
[2]students' AMA dues for the calendar year 1992

*Physicians in these categories may be eligible for exemption from AMA dues under the grandfather clause. (AMA dues-exempt members who were granted exemption before 1986 based on previously established criteria, with the exception of financial hardship or disability, will automatically be exempt from dues in 1986 and the years following.)

Current AMA policy provides for only two categories of exemptions: financial hardship or disability and 70 years of age or older and fully retired. AMA dues for under-age-70 and fully retired members may be reduced to $80.

State society dues are prorated on a monthly basis for those elected to membership July 1 through Aug 31. Those elected after Aug 31 are exempt from dues for the balance of the year in which they are elected. AMA dues are prorated on a semiannual basis.

To begin the membership process, contact your county medical society or call the Communications Division of the SMS at 1-800-362-9080 or 608-257-6781.[15th]

Marquette University Gospel Choir under the direction of Rev. Barry Ward.

SMS officers and directors by district

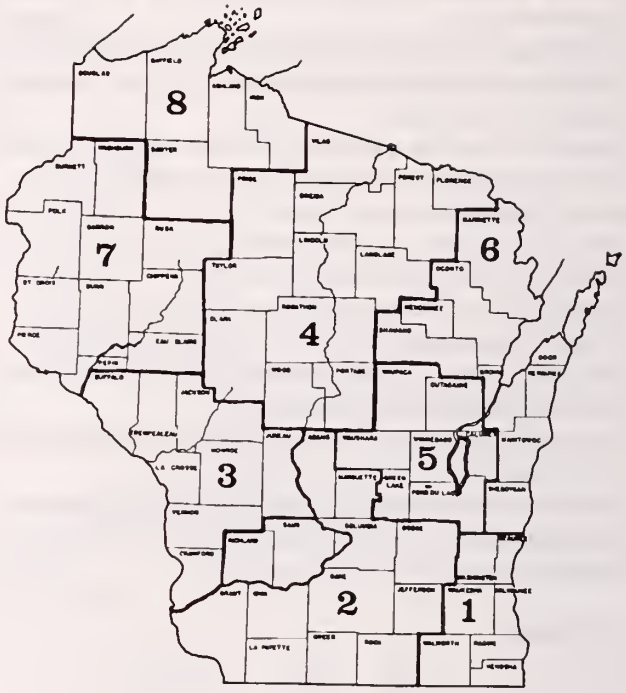
Officers of the society
President (1992-1993)
William J. Listwan, MD
205 Valley Ave, West Bend 53095

President elect (1992-1993)
Pauline M Jackson, MD
1836 South Ave, La Crosse 54601

Executive Vice President & Secretary (1992-1993)
Thomas L Adams, CAE
330 E Lakeside St, PO Box 1109, Madison 53701

Treasurer (1992-1993)
William P. Crowley, Jr, MD
20 S Park St, Madison 53715

Board of Directors
Chair: Richard H. Ulmer, MD
Vice Chair: Raymond C. Zastrow, MD



District 1
Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, and Waukesha counties

Timothy G. McAvoy, MD (1990/1990-1993)
1751 East Main, Waukesha 53186

Marvin G. Parker, MD (1990/1990-1993)
1525 Howe St, Racine 53403

Charles E. Pechous, Jr, MD (1990/1990-1993)
6530 Sheridan Rd, Kenosha 53140

Marcia J. S. Richards, MD (1988/1990-1993)
2900 W Oklahoma Ave, PO Box 2901,
Milwaukee 53201-2901

John E. Ridley, III, MD (1990/1990-1993)
2315 N Lake Dr, Ste 1001, Milwaukee 53211

Jay F. Schamberg, MD (1991/1991-1993)
8901 W Lincoln St, West Allis 53227

George R. Schneider, MD (1989/1991-1994)
9330 W Lincoln Ave, West Allis 53227

Richard H. Strassburger, MD (1988/1991-1994)
161 W Wisconsin Ave, Ste 4016, Milwaukee 53203

Robert F. Purtell, Jr, MD (1989/1992-1995)
3316 W Wisconsin Ave, Milwaukee 53208

Thomas A. Reminga, MD (1986/1992-1995)
330 E Kilbourn, Ste 730, Milwaukee 53202

Raymond C. Zastrow, MD (1987/1992-1995)
2400 W Villard Ave, Milwaukee 53209

District 2
Adams, Columbia, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Marquette, Richland, Rock, and Sauk counties

Andrew B. Crummy, Jr, MD (1992/1992-1993)
D4/348 UW CSC, 600 Highland Ave, Madison 53792

Jerry M. Ingalls, MD (1992/1992-1994)
1515 Tenth St, Monroe 53566

William L. Kopp, MD (1989/1991-1994)
1313 Fish Hatchery Rd, Madison 53715

Sandra L. Osborn, MD (1987/1991-1994)
104 Shiloh Dr, Madison 53705

Ayaz M. Samadani, MD (1991/1991-1994)
PO Box 678, 148 Warren Street, Beaver Dam 53916

John D. Wegenke, MD (1986/1992-1995)
345 W Washington Ave, Madison 53703

District 3
Buffalo, Crawford, Jackson, Juneau, La Crosse, Monroe, Trempealeau, and Vernon counties

Mark Andrew, MD (1992/1992-1995)
125 W Jefferson, Viroqua 54665

Jack M. Lockhart, MD, (1989/1992-1995)
1836 S Avenue, La Crosse 54601

District 4
Clark, Florence, Forest, Langlade, Lincoln, Marathon, Oneida, Portage, Price, Taylor, Vilas, and Wood counties

Robert J. Jaeger, MD (1988/1991-1994)
3291 Thompson Court, Stevens Point 54481

William E. Raduege, MD (1986/1992-1995)
PO Box 1387, 1112 E 3rd St, Woodruff 54568

Richard H. Ulmer, MD (1986/1992-1995)
1000 N Oak Ave, Marshfield 54449

District 5
Calumet, Fond du Lac, Green Lake, Outagamie, Waupaca, Waushara, Winnebago and counties

Donn D. Fuhrmann, MD (1988/1990-1993)
1420 Algoma St, New London 54961

Harry J. Zemel, MD (1987/1991-1994)
323 Maple Ave, Fond du Lac 54935

James L. Basiliere, MD (1986/1992-1995)
414 Doctors Court, Oshkosh 54901

District 6
Brown, Door, Kewaunee, Manitowoc, Marinette, Menominee, Oconto, Shawano, and Sheboygan counties

Joseph C. DiRaimondo, MD (1985/1991-1994)
1636 Miriam Rd, Manitowoc 54220

Stephen D. Hathway, MD (1989/1992-1995)
PO Box 23400, Green Bay 54305

John E. Kraus, MD (1986/1992-1995)
1510 Main St, Marinette 54143

District 7
Barron, Chippewa, Dunn, Eau Claire, Pepin, Pierce, Polk, Rusk, St Croix, Burnett, and Washburn counties

Philip J. Happe, MD (1985/1991-1994)
823 Bradley Ave, Eau Claire 54701

Lloyd R. Cotts, MD (1992/1992-1995)
1020 Lakeshore Dr, Rice Lake 54868

District 8
Ashland, Bayfield, Douglas, Iron, and Sawyer counties

Robert L. Sellers, MD (1987/1990-1993)
69 N 28th Street, Superior 54880

Continued on next page

"Indiana" Listwan begins his presidential adventure.

Continued from preceding page

Officers of the Society

President: William J Listwan, MD (1992-1993)
205 Valley Ave, West Bend 53095
President elect: Pauline M Jackson, MD (1992-1993)
1836 South Ave, La Crosse 54601
Immediate past president: Cyril M. Hetsko, MD (1992-1993)
1313 Fish Hatchery Rd, Madison 53715

Speaker: Richard G. Roberts, MD (1991-1993)
777 S Mills St, Madison 53715
Vice speaker: Kenneth I. Gold, MD (1992-1994)
1905 Huebbe Parkway, Beloit 53511

Ex officio, without vote:
Executive Vice President and Secretary Adams; Treasurer Crowley;
Christopher Smith, medical student, University of Wisconsin-Madison;
Michael Bigelow, medical student, Medical College of Wisconsin.

Delegates to the AMA
Richard W. Edwards, MD (1991/1992 & 1993)
1313 W Seminary St, Richland Center 53581
Timothy T. Flaherty, MD (1991/1992 & 1993)
547 E Wisconsin Ave, Neenah 54956
John D. Riesch, MD (1991/1992 & 1993)
PO Box 427, Menomonee Falls 53051
John P. Mullooly, MD (1992/1993 & 1994)
8430 W Capitol Dr, Milwaukee 53222
John K. Scott, MD (1992/1993 & 1994)
20 S Park St, #350, Madison 53715
Patricia J. Stuff, MD (1990/1993 & 1994)
PO Box 366, Bonduel 54107

Alternate Delegates to the AMA
J D Kabler, MD (1991/1992 & 1993)
5501 Varsity Hill, Madison 53705
Richard H. Ulmer, MD (1991/1992 & 1993)
1000 N Oak Ave, Marshfield 54449
Kenneth M. Viste, Jr, MD (1991/1992 & 1993)
100 Stoney Beach Rd, Oshkosh 54901
Jerome W. Fons, Jr, MD (1992/1993 & 1994)
3734 W Coldspring Rd, Greenfield 53221
Cyril M. Hetsko, MD (1992/1993 & 1994)
1313 Fish Hatchery Rd, Madison 53715
Robert F. Purtell, Jr, MD (1992/1993 & 1994)
3316 W Wisconsin Ave, Milwaukee 53208

Young Physicians Section Delegates to the AMA
Kevin A. Jessen, MD (1992-1994)
1112 Charles Dr, Tomah 54660
Kevin T. Flaherty, MD (1992-1994)
PO Box 689, Wausau 54402-0689

YPS Alternate Delegate to the AMA
Susan Turney, MD (1991-1993)
1000 N Oak Ave, Marshfield 54449-5777

Note: Officers, directors, delegates, alternate delegates, and members of commissions and committees are elected at the Annual Meeting (April 1992). Dates in parentheses indicate year of appointment and beginning and expiration of terms of office. AMA delegates and alternate delegates' terms of office are on a calendar basis, although elected at the annual meeting.[15th]

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Danny Thomas Founder

SMS resource directory

TIMELY, ACCURATE INFORMATION is essential in our complex, rapidly changing medical environment. Information—when you need it—on scientific issues, legislative issues, and socioeconomic issues is available from the SMS headquarters in Madison.

This SMS resource directory is provided as a brief reference guide to assist you in locating the resource person on the SMS staff who is best able to answer your questions on a wide variety of topics.

Simply call 1-800-362-9080 for immediate access to this valuable membership resource.

A

Accounting ..... Jim Esselman
Accounts payable
  SMS Holdings, Corp ..... Kris Hensen
  SMS/WMJ ..... Rick Koffarnus
Accounts receivable
  SMS Holdings, Corp ..... Marcella Herfel/Kris Hensen
  SMS/WMJ ..... Marcella Herfel/Kris Hensen
  Membership dues ..... County societies/ Joyce Pease/Jim Paxton
  Insurance premiums ..... Heidi Ness
Accreditation for CME ..... Kristin Krueger
Address changes ..... Joyce Pease
Administrative rules (state) ..... Michael Kirby/Don Lord/Sally Wencel
Advanced medical directives ..... Sally Wencel/Linda Boyd
Aesculapian Society ..... Julie Hein
Aging and extended care facilities ..... Linda Boyd
AIDS ..... Don Lord
Alcoholism and other drug abuse ..... Cecilia Geis
Allied health personnel ..... Sally Wencel
AMA-delegates, policies and activities ..... Jim Paxton/Tom Adams
Annual meeting ..... Kristin Krueger
Antitrust ..... Mark Adams/Sally Wencel
Audits (T-18), T-19, WIPRO) ..... Trish Ramsay
Auxiliary ..... Maria Van Cleve

B

Beaumont 500 ..... Julie Hein
Board of Directors ..... Tom Adams/Jim Paxton
Bylaws: state and county medical ..... Sally Wencel/Mark Meyer

C

Capitol Update ..... Michael Kirby/Don Lord
CHAMPUS ..... Trish Ramsay
Charitable, Educational and Scientific Foundation ..... Julie Hein
CLID ..... Trish Ramsay
Claim forms ..... Bill Guerten
Coding ..... JoAnn Steigerwald
Communications ..... Russell King/Shari Hamilton
Complaints about medical care ..... Sally Wencel
  Dane County ..... J. Michael Eaton
Computers ..... Doug Turecek
Consent forms ..... Sally Wencel
Continuing medical education ..... Kristin Krueger
Cost containment activities ..... Mary Barham
County medical society affairs including Constitution and Bylaws ..... Sally Wencel/ field representatives

D

Data collection ..... Mary Barham
Data systems ..... Doug Turecek
Discipline of physicians ..... Sally Wencel
Donations (monetary, real property, in-kind ..... Julie Hein
DRGs ..... Trish Ramsay

E

Economic information ..... Mary Barham
Editorial Board ..... Russell King/Shari Hamilton
Emergency medical services ..... Sally Wencel
Environmental health ..... Cecilia Geis
Ethics ..... Sally Wencel/Linda Boyd

F

Fees for medical care or other physician services ..... Sally Wencel

Continued on next page

William Malkasian, CAE, (l) presents Ken Viste, Jr, MD, (r) with an Award of Excellence on behalf of the American Society of Association Executives. Dr Viste accepted the award on behalf of the SMS PartnerCare program.

Continued from preceding page

Field Staff ..... Mark Meyer/Martin Mulcahey/ Cheryl McCollum/Steve Whittow
Fort Crawford Medical Museum ..... Julie Hein
Foundation (CESF) ..... Julie Hein

G

General management of SMS ..... Tom Adams/Jim Paxton
Governmental affairs ..... Michael Kirby/Don Lord
Grants for special projects ..... Julie Hein

H

HSS-124 Hospital Code ..... Sally Wencel
Health care financing ..... Mary Barham/Trish Ramsay
Health care data ..... Mary Barham
Health care for the uninsured ..... Trish Ramsay
Health insurance
  third-party carriers ..... Trish Ramsay
  for SMS members ..... Jan McChesney
Health manpower ..... Trish Ramsay
HMOs ..... Mary Barham
Home health ..... Linda Boyd
Hospital bylaws ..... Sally Wencel
Hospital medical staff section ..... Cathy Duster
Hospital-physician relations and
  due process ..... Sally Wencel
Hospitals and health facilities ..... Sally Wencel
House of Delegates ..... Tom Adams/Jim Paxton

I

Impaired physicians ..... Sally Wencel
Insurance and membership programs
  Insurance ..... Jan McChesney/Heidi Ness

- *Annuities
- *Auto
- *Dental Protection Plan
- *Overhead expense
- *Funding of claims made tail coverage
- *Professional liability
- *Life
- *Office
- *Disability
- *Personal property
- *Personal umbrella
- *Health
- *Retirement plans

Membership programs ..... Noreen Krueger/Lee Johnson

- *Auto leasing plan
- *Avis or Hertz rental plan
- *Collection service
- *Credit cards
- *Medical equipment leasing/discounts
- *Worker's compensation

International Medical Graduates ..... Cecilia Geis
Interns and residents ..... Linda Boyd
IPAs ..... Mary Barham

J

(JCAHO) Joint Commission on Accreditation
  of Health Organizations ..... Sally Wencel

L

Legal information ..... Sally Wencel
Legislation and regulations
  state ..... Michael Kirby/Don Lord/ field representatives
  Federal ..... Michael Kirby
Liability insurance coverage ..... Alice Ballweg/Charlie Sitkiewitz
Liability insurance regulation ..... Mark Adams
Licensure of physicians and others ..... Sally Wencel
Living wills ..... Don Lord/Sally Wencel
Long-term care ..... Linda Boyd
Long-term care insurance ..... Heidi Ness

M

Mailing labels ..... Jim Lundberg/ Joyce Pease
Managed care ..... Mark Adams/Sally Wencel
Maternal and child health ..... Cathy Duster
Maternal mortality study ..... Cathy Duster
Media relations ..... Russell King/Shari Hamilton
Mediation panels ..... Mark Adams
Mediation and peer review ..... Sally Wencel
Medicaid (T-19) ..... Cathy Duster
Medicaid audits ..... Cathy Duster
Medical assistants ..... JoAnn Steigerwald
Medical history ..... Julie Hein
Medicolegal issues ..... Mark Adams/Sally Wencel
Medical liability ..... Mark Adams/Cecilia Geis
Medical liability (legislative information
  and related matters) ..... Michael Kirby/Mark Adams
Medical museum, Prairie du Chien ..... Julie Hein
Medical Policy and Practice Division ..... Mary Barham
Medical records ..... Sally Wencel
Medical student loans
  Applications ..... Julie Hein
  Repayments ..... Norma Swenson/ Jane Anderson
Medical student section ..... Linda Boyd
Medicare (T-18) ..... Trish Ramsay/Linda Boyd
Medicare audits ..... Trish Ramsay/Linda Boyd
Medicine and ethics ..... Linda Boyd
Medigram ..... Shari Hamilton/Russell King
Membership
  County societies ..... Joyce Pease/Jim Paxton
Membership Committee ..... Jim Paxton
Membership recruitment and
  retention ..... Joyce Pease/Jim Paxton
Mental health ..... Cecilia Geis

N

National Practitioner Data Bank ..... Sally Wencel/Cecilia Geia
Negotiations ..... Tom Adams
Newspapers-news releases ..... Russell King/Shari Hamilton
Nursing ..... Sally Wencel
Nursing homes ..... Linda Boyd

O

Occupational health ..... Cecilia Geis
Occupational Health Guide ..... Julie Hein

P

Pamphlets on health care ..... Russell King

PartnerCare ..... Trish Ramsay
Patient Compensation Fund ..... Mark Adams
Peer review ..... Sally Wencel
Personnel ..... Barbara Kopenski
Physicians for Better Government ..... Michael Kirby/ field representatives
Physician information biographical ..... Joyce Pease
Physician recognition award ..... Kristin Krueger
Physician referrals
  Dane County ..... Chris Long
  Other counties ..... Joyce Pease
Physician income ..... Mary Barham
Physician Support Program ..... Cecilia Geis
Political action ..... Michael Kirby/ field representatives
Power of attorney for health care ..... Sally Wencel
Practice management seminars ..... Karen Garrett
Practice parameters ..... Cathy Duster
Printing ..... Dave Conner
Professional liability (legislative information and related matters ..... Michael Kirby/Mark Adams
Professional liability insurance ..... Alice Ballweg
Property management-SMS ..... Don Temby
PRO ..... Trish Ramsay
Public affairs ..... Michael Kirby
Public health ..... Linda Boyd
Public information ..... Russell King/Shari Hamilton
Public relations ..... Russell King/Shari Hamilton

Q

Quality assurance ..... Cathy Duster/Sally Wencel

R

Radio ..... Russell King/Shari Hamilton
RBRVS ..... Trish Ramsay/Linda Boyd
Resident physicians ..... Linda Boyd
Risk management ..... Mark Adams/Cecilia Geis
Rural health ..... Trish Ramsay/Michael Kirby

S

Safe Transportation ..... Cecilia Geis
Savant syndrome information ..... Julie Hein
School health ..... Cathy Duster
Scientific affairs ..... Kristin Krueger
Seminars ..... Karen Garrett
Specialty society services ..... J. Michael Eaton
Student loans and scholarships
  applications ..... Julie Hein
  repayments ..... Norma Swenson/Jane Anderson
Student Section activity ..... Linda Boyd
SMS Holdings Corp
  accounts receivable ..... Marcella Herfel/Kris Hensen
  accounts payable ..... Kris Hensen
  Lakeside Association Services, Inc. ..... J. Michael Eaton/ Kathy Mohelnitzky/Jackie Millar
  Lakeside Administrators ..... Jeanette Edwards/Wayne Kostka
  claim forms ..... Bill Guerten
  printing ..... Dave Conner
  endorsed programs ..... Noreen Krueger/Lee Johnson
  general management ..... Lee Johnson
  insurance premiums ..... Jan McChesney
  premiums ..... Jan McChesney
  SMS Service Insurance Plans ..... Jan McChesney/Heidi Ness

T

Tax problems ..... Sally Wencel
Television ..... Russell King/Shari Hamilton
Title 18 (Medicare) ..... Trish Ramsay
Title 19 (Medicaid) ..... Cathy Duster
Tourette Syndrome Physician Guides ..... Julie Hein

U

Utilization review ..... Sally Wencel/Mary Braham

W

WHCLIP (Wisconsin Health Care Liability Insurance Plan) ..... Mark Adams
Wisconsin Ambulatory Medical Care Survey ..... Mary Barham
Wisconsin Association of Senior Physicians (WASP) ..... Julie Hein
Wisconsin Medical Journal ..... Russell King/Shari Hamilton
Wisconsin Peer Review Organization (WIPRO) ..... Trish Ramsay/Sally Wencel
WIPRO audits ..... Trish Ramsay
WISPAC ..... Michael Kirby/ field representatives
Worker's compensation ..... Cecilia Geis/ Michael Kirby/Sally Wencel/Mark Adams

Y

Young Physicians Section ..... Trish Ramsay

150 YEARS OF CARING
THE STATE MEDICAL SOCIETY OF WISCONSIN

Publications and reprints available

A NUMBER OF BROCHURES are available from the SMS. Most are intended as patient-education materials on scientific and socioeconomic issues; others are useful as physician-education tools on socioeconomic and legislative topics. Some are available free of charge, while others require a nominal charge. Call the SMS Division of Communications for more information (unless indicated otherwise): 1-800-362-9090, or in Madison, 257-6781.

DME Medicare Part B Reference Manual
This manual is WPS-Medicare's official DME reference manual and provides information on basic Medicare claims filing guidelines, payment policies, reimbursement, audits and reviews, and special instructions for specific equipment. It is distributed as part of the SMS's DME Medicare seminar. The manual costs $49 plus state and county tax when applicable. Checks should be made payable to the State Medical Society and sent: Attn: Karen Garrett, SMS, P.O. Box 1109, Madison, WI 53701. Published in 1992.

Facts About Malignant Melanoma
Part of the revived HEALTH WATCH series, this patient education brochure explains who is most at risk, how to detect and prevent melanoma, and how to conduct a self-examination. Published in 1988.

Health Care Reform: Where do you Stand?
Reform of the health care system has become one of the major issues facing this country and state in 1992. A discussion tool for SMS members, this booklet addresses current problems such as: rising numbers of uninsured and underinsured; soaring health care costs; and expensive insurance premiums. Published in 1992.

If You Have a Complaint About Medical Care
This brochure explains the SMS's grievance and peer review system. Published in 1983.

The Liability Crisis in Wisconsin
A patient education brochure that explains why your patients should care about your medical liability costs, what the

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717 South Beaumont Road
Prairie du Chien, WI 53821
1-800-545-0634

problem is, and what they can do about it. The emphasis of the brochure is on the value of a cap on non-economic awards. Published in 1989.

Medical Professional Liability Insurance: Claims Made or Occurrence?
This brochure explains for physicians how the policies work, how premiums are established, how coverage is terminated, the limits of liability and how to decide between the types of coverage. The brochure was produced by the SMS Young Physicians Section and is particularly useful for physicians just beginning their practice. Published in 1989.

Medicare Part B Reference Manual
This manual, written cooperatively by the SMS and WPS-Medicare, is WPS-Medicare's official reference manual for Medicare Part B and provides information on basic Medicare claims filing guidelines, payment policies, reimbursement, and audits and reviews. It is updated yearly and distributed as part of SMS's fall Medicare seminar. The manual costs $25 plus state and county tax when applicable. Checks should be made payable to the State Medical Society and sent: Attn: Karen Garrett, SMS, P.O. Box 1109, Madison, WI 53701. Published in 1992.

Occupational Health Guide
This newly revised edition contains information for medical and nursing personnel in the commercial and industrial setting. Entitled "Your Body In The Workplace," the guide includes the Employee's Right to Know Law and the OSHA Bloodborne Pathogens Final Standards. Complete guide with binder, $75 each; including shipping. Wisconsin residents add 5% sales tax and county tax when applicable. Make checks payable to: CES Foundation; P.O. Box 1109, Madison, WI 53701. Payment must accompany the order. Published in 1992.

Operation Reform: The Partnership for Better Health Care
Following eight months of discussion with business and health care leaders throughout Wisconsin, a comprehensive package of cost containment initiatives was developed by the SMS, Wisconsin Manufacturers and Commerce, Association of Wisconsin HMOs and the Wisconsin Hospital Association. This brochure outlines the group's proposals. Published in 1991.

OSHA Reference Manual
This manual is designed to assist physicians and their office staff in complying with the new Occupational Health and Safety Administration's Bloodborne Pathogens Standard. It was distributed at the SMS's OSHA seminars. The manual costs $25 plus state and county tax when applicable. Checks should be made payable to the State Medical Society and sent: Attn: Karen Garrett, SMS, P.O. Box 1109, Madison, WI 53701. Published in 1992.

The illuminati at the SMS House of Delegates shine so brightly that Speaker Roberts has to wear shades.

PartnerCare
A poster and brochure aimed at educating elderly low-income patients about this important SMS voluntary Medicare assignment program. Contact the SMS Division of Medical Policy and Practice for more information. Published in 1990.

A Physician's Guide to Wisconsin Health Law
This handbook deals with the more important legal and socioeconomic issues affecting the practice of medicine in Wisconsin. The information in this book will help you avoid pitfalls, answer your patients' questions, ask the right questions when you need counsel, and become a more involved and effective voice for the profession. To order, please contact call *Wisconsin Medical Journal* offices at SMS. Published in 1991.

A Practical Guide to Public Relations
This booklet is designed to assist Wisconsin's county medical societies to enhance their public relations efforts in their own communities. Published in 1988.

Putting the UCR Fee Puzzle Together
Explains what "usual, customary and reasonable" means,

how misunderstandings concerning it can be avoided and how problems can be resolved when they occur. The small size of this brochure makes it suitable for enclosure in office statements or for placement in patient reception areas. Published in 1990.

Questions and Answers on Smokeless Tobacco
Part of the revived HEALTH WATCH series, this patient education brochure explains smokeless tobacco and its dangers in very plain language. Published in 1988.

School Health Examination
A guide for physicians and school authorities in establishing a program of school health examinations. Single copy $2.00 plus 5% sales tax and county tax when applicable. Make checks payable to: CES Foundation, P.O. Box 1109, Madison, WI 53701. Payment must accompany the order. Published in 1983.

Update REACH: Resource for Education Awareness of Community Health
Examining the changing nature of the public's image of physicians and explaining SMS media policies and programs on current medical issues. Published in 1985.

Vaccine Information
Effective April 15, 1992, physicians and others are required to provide a copy of educational materials to parents before administering each and every dose of the vaccines covered by the National Childhood Vaccine Injury Compensation Act of 1986, including vaccines for measles, mumps, rubella, oral or inactivated polio, diphtheria, tetanus and pertussis. Pamphlets may be ordered in bulk from the American Academy of Pediatrics at a rate of $20 per 100 for nonmembers; $15 per 100 for members. Questions? Call (708) 981-7878.

Worker's Compensation
The SMS makes available to physicians several brochures and booklets designed to ease the burden of worker's compensation cases. Titles include: "How to Evaluate Permanent Disability," published in 1987; "Wisconsin Doctors and Worker's Compensation," published in 1987; and "Using the WC-16B for Worker's Compensation," published in 1986.

You and Your Medical Debt
This booklet explains how to prevent and repay debt. It also details your rights as a consumer owing money for medical expenses. The booklet was produced with grants from Consumer Federation of America, Dane County Bar Association Research and Education Foundation, and the State Medical Society of Wisconsin Charitable, Educational and Scientific Foundation. You may order a free copy of the booklet by calling the Center for Public Representation at (608) 251-4008. Published in 1992.

Your Right to Direct Your Future Health Care
Facing questions on advance directives? The SMS now has pamphlets for patients explaining advance directives and medical treatment decision making. This easy-to-read, nontechnical pamphlet will help you respond to the anticipated increase in patient questions about these issues as the result of a new law. As of Dec. 1, 1991, all federally-certified nursing homes, hospitals, home health agencies, hospices, personal care agencies, and health maintenance organizations are required under the new federal Patient Self-Determination Act to provide written information to patients describing their rights regarding self-determination of medical care. As a result, many patients will be looking to their doctors for information. This brochure was developed by the Wisconsin Division of Health in cooperation with the SMS and other organizations. Published in 1991.

Physician briefs

George W. Arndt, MD,* of Neenah, will serve a 3-year term on the new examination board of the Federation of State Medical Boards. Dr Arndt has been a licensed physician in Wisconsin since 1954 and a practicing psychiatrist for more than 30 years.

Richard H. Aster, MD,* of Brookfield, has been chosen to receive the Distinguished Service Award from the Medical College of Wisconsin, the highest award given to faculty. Dr Aster, a hematologist, has been president of the Blood Center of Southeastern Wisconsin since 1970 and served from 1986 to 1991 as acting director of the MCW Cancer Center. He is an internationally recognized physician, scientist and medical administrator, and a leading authority on blood platelets.

Samuel S. Blankenstein, MD,* of Milwaukee, is the recipient of the first annual Distinguished Service Award presented by the Milwaukee Ophthalmological Society. The honor is awarded to individuals who have made significant contributions in the field of ophthalmology through service and education.

Brian L. Goldshlack, MD,* a family physician, has accepted a position with the newly established Columbia-Bay View Medical Clinic in Milwaukee. Dr Goldshlack is a graduate of Ross University School of Medicine. He completed his medical residency at the Medical College of Wisconsin affiliated hospitals and recently was affiliated with the Urgent Care Center of Milwaukee Medical Clinic.

John T. Henningsen, MD,* of Rice Lake, has joined an effort providing medical relief in Siberia. More than $5 million worth of supplies for the mission were gathered by two organizations from the Fox River Valley, Physicians for Social Responsibility and a Sister City group.

Christopher M. Inglese, MD, has joined the La Salle Clinic's medical staff in Menasha. Dr Inglese is a pediatric neurologist, specializing in providing care for children with epilepsy, cerebral palsy, spina bifida and juvenile migraines. Dr Inglese practiced for 5 years at Associated Neurologists of Southern Connecticut in Bridgeport. He is a graduate of the University of Bologna Medical School in Bologna, Italy. He served a residency in pediatrics at Yale University's Bridgeport (Conn) Hospital.

Robert Johnson, MD,* of the River Falls Medical Clinic, received the Dr. John Eckdale Health Professional Award from the American Diabetes Association recently in Minneapolis. The regional award was presented to Dr Johnson in part for his work on behalf of Camp Needlepoint in Troy, a camp for young diabetic campers sponsored by the River Falls Lions Club.

Fred A. Karsten, MD,* has announced his August retirement. Dr Karsten began practicing medicine in Horicon in 1958, joining his father, John H. Karsten, MD, in practice there. His grandfather, Adrian C. Karsten, MD, first came to practice in Horicon in 1892. The three generations of Karstens served Horicon and the surrounding area for a total of 106 years.

Richard Ulmer, MD, of Marshfield, delivers his address as chair of the SMS Board of Directors.

Richard D. Larson, MD, has joined Mercy Center for Family Medicine in Janesville. He will also serve as associate director of the Southern Wisconsin Family Practice Residency Program. Dr Larson practiced in Fort Atkinson for the past 19 years.

Sanford Larson, MD, chair of the Medical College of Wisconsin Department of Neurosurgery for nearly 30 years, has been selected to receive MCW's Distinguished Service Award. Dr Larson has written more than 125 original papers and 25 books and chapters and is a prominent expert in the field of spinal trauma. He has served as president of the Cervical Spine Research Society, is a founding member of the American Association of Neurological Surgeons and chair of the Joint Section of Spine Disorders of the American Association of Neurological Surgeons and the Congress of Neurological Surgeons.

J. David Lewis, MD,* a general and vascular surgeon at the General Clinic of West Bend, has become the new president of the Wisconsin Surgical Society, a organization representing more than 300 surgeons in the state. Dr Lewis earned his medical degree from the University of Tennessee and has been associated with the General Clinic for 14 years.

Michael D. Liebe, MD,* has announced plans to join the medical staff of St Mary's Hospital in Sparta in August. Dr Liebe received his medical degree from the University of Minnesota and recently completed a family practice residency in La Crosse.

Elaine Mischler, MD, professor of pediatrics at UW Medical School and a pediatrician at UW Children's Hospital, has been named the 1992 Pediatrician of the Year by the Wisconsin Academy of Pediatrics. Dr Mischler was honored for her work in cystic fibrosis. A pediatrician since 1970, she received her medical degree from the University of Pennsylvania School of Medicine. Dr Mischler, of Waunakee, now serves as director of the Pediatric Pulmonary Center, one of nine centers in the nation federally designated to train graduate students in medicine, nursing, respiratory therapy, social work, nutrition and pharmacy.

John Olson, MD, a Marshfield Clinic internist, has received the Wisconsin Medical Alumni Association Distinguished Teaching Award for 1992. Dr Olson, a Rice Lake native, earned his medical degree from the University of Wisconsin Medical School. He joined Marshfield Clinic in August 1989.

Continued on next page

Patrick Regan, MD,* chair of the Department of Medicine at Columbia Hospital in Milwaukee, has been named recipient of the Premier Physician Award by the Wisconsin Chapter of the Crohn's and Colitis Foundation of America, Inc. Dr Regan is regional medical adviser for the midwest region of the foundation.

David C. Riley, MD,* has been appointed medical director of the Waupon Memorial Hospital Emergency Department. Dr Riley received his medical degree from the Medical College of Wisconsin and served his internship and residencies in Milwaukee.

Mark A. Sager, MD,* has accepted a post at the University of Wisconsin Medical School. Dr Sager is the former head of Dean Medical Centers-St Marys Hospital Geriatric Clinics. He will do clinical geriatric research for the medical school's department of medicine.

Claude W. Schmidt, MD,* retired June 30 from active practice at the Moreland Obstetrics and Gynecology Associates in Waukesha. Schmidt has been practicing in Waukesha for more than 40 years.

Sidney Shindell, MD, a Milwaukee medical educator for 26 years, has announced his candidacy for the Republican nomination for the Fifth Congressional District. A 1951 graduate of the George Washington University Law School, Dr Shindell is a professor and chairman emeritus of the Medical College of Wisconsin's Department of Preventative Medicine.

Mark Siegel, MD, has accepted the position of medical director for child and adolescent services at Milwaukee Psychiatric Hospital in Wauwatosa.

John J. Smalley, MD,* has joined the medical staff of the newly approved Sparta clinic, affiliated with St Mary's Hospital and the Franciscan Health System. Dr Smalley has been a general surgeon in La Crosse for 22 years. Board certified, he received his medical degree from the University of Illinois College of Medicine and completed his residency in general surgery at the University of Illinois.

WISPAC and Physicians for Better Government

The Wisconsin Physicians Political Action Committee (WISPAC) is a voluntary, nonprofit organization open to physicians and their spouses. Restricted from making political contributions, the SMS created WISPAC to provide the medical profession an opportunity to become more politically active and effective. WISPAC is governed by a board of directors, traditionally concentrates on state legislative races, and cooperates with the Amercan Medical Political Action Committee (AMPAC) on federal issues.

Physicians for Better Government is a direct giver program, or political conduit, established in 1987 by the SMS. Political conduits differ from political action committees in that contributors retain the right to decide who receives their individual contributions. Physicians for Better Government contributions are deposited in a special account in each contributor's name. No contribution is made to a candidate without the contributor's authorization.

WISPAC and Physicians for Better Government are administered by the SMS Division of Public Affairs, pursuant to state statutes and administrative rules authorizing and regulating these programs. For additional information call 608-257-6781 or 1-800-362-9080.

Contributions may be sent to: Physicians for Better Government/WISPAC, PO Box 2595, Madison, WI 53701.

Suggested membership categories include:

- $200 Sustaining member
  ($100 Physicians for Better Government, $50 WISPAC, $50 AMPAC)
- $100 Sponsor
  ($50 Physicians for Better Government, $30 WISPAC, $20 AMPAC)

Contributions at the above levels authorize PFBG to transfer the amounts shown to WISPAC and AMPAC. If you wish to contribute differently, you may allocate amounts of your choice, per the examples below:

- $50 Physicians for Better Government only
- $50 WISPAC/AMPAC ($30 WISPAC, $20 AMPAC)
- $30 WISPAC only

County society news

Milwaukee. Two new members of the Medical Society of Milwaukee County are Julian E. De Lia, MD, and Beth A. Derfus, MD. Dr De Lia's specialty is OB/GYN, and Dr Derfus' specialty is in internal medicine.

Racine. Debra L. Jaryszak, MD, recently was elected to membership in the Racine County Medical Society.

Rusk. Bradley Hiner, MD, neurologist from the Marshfield Clinic, spoke on Parkinson's Disease at a recent meeting of the Rusk County Medical Society.

Wayne Spradley, MD, and Michael Grebner, MD, have joined Family Health Plan Cooperative, a Milwaukee health maintenance organization. Dr Spradley, an internist, is stationed at the Edgerton Health Center while Dr Grebner, a family practice physician, will see patients at Airport Health Center in Milwaukee.

William H. Stone, MD,* of Burlington, recently received the Frank Tobin Award for Youth Services, presented by the Burlington Kiwanis. A hematologist and oncologist, Dr Stone is vice president of medical affairs at Memorial Hospital of Burlington and medical director of Burlington Clinic.

Morgan E. Warffuel, MD,* formerly of Monroe, has joined Group Health Cooperative in Eau Claire. Dr Warffuel earned his medical degree from the American University of the Caribbean and completed a family practice residency program at Sinai Samaritan Medical Center in Milwaukee.[150th]

Obituaries

Walter P. Blount, MD, 91, of Milwaukee, died May 14, 1992, in Milwaukee. Dr Blount was born July 3, 1900, in Oak Park, Ill, and graduated from Rush Medical School in 1925 and served his internship at Madison General Hospital (now Meriter) in Madison. His residency in orthopedic surgery was completed at Wisconsin General Hospital (now University Hospital and Clinics) in Madison. Dr Blount studied orthopedic surgery in Europe and in 1929 returned to Milwaukee and set up his medical practice. He became affiliated with Marquette University School of Medicine in 1932 where he served as chair of the orthopaedic surgery department from 1957 to 1968. Dr Blount and Dr Albert Schmidt developed the well-know "Milwaukee Brace" in 1946. Dr Blount received a Distinguished Service Award from the Medical College of Wisconsin in 1973 and an honorary degree in 1979. He is truly considered a giant among orthopaedic surgeons in this country and abroad. He was vice president of Society Internationale de Chirugie Orthopedique et de Traumatologic (SICOT) as well as chair of the US Section. He was president of the American Academy of Orthopaedic Surgeons, Clinical Orthopaedic society and Milwaukee Academy of Medicine, a founder of the Contemporary Orthopaedic Club and the Wisconsin Orthopaedic Society, and a member of the American Orthopaedic Association. Dr Blount also was a member of the Board of Associate Editors of the *Journal of Bone and Joint Surgery* and of the Board of Governors of the American College of Surgeons. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Marion; one son, Ralph, of Citrus Heights, California.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.[150th]

Samuel L. Chase, MD, 86, of Madison, died April 28, 1992, in Madison. He was born in Madison on March 15, 1906, and graduated from the College of Physicians and Surgeons in New York. His internship and residency were completed at Bellevue Hospital, New York. He had a medical practice in New York with teaching positions in the Surgical Services of Bellevue Hospital and also was a professor of clinical surgery at New York University Medical School. He served for more than 4 years in World War II. After service he practiced in Madison from 1946 to 1973 when he became a medical consultant for the Social Security Disability Bureau. He was a member of the American College of Surgeons, the Wisconsin Surgical Society, the Dane County Medical Society, the SMS, and the AMA. Surviving is his widow, Nettie, of Madison.

Lewis B. Harned, DO, 95, of Madison, died May 2, 1992, in Madison. Dr Harned was born in Dallas City, Ill, in March 1897. He graduated from the Chicago College of Osteopathy in 1919. He opened his practice in Madison in 1921. He served in the US Navy during World War I. Surviving are his widow, Ermil; three sons, Dr Lewis, of Madison, Brigadier General (USAF Retired) Donne C., of Blue Mounds, and Dr Roger, of Omaha; 12 grandchildren, and eight great grandchildren.

Bruce H. Kaufman, MD, 43, of Whitefish Bay, died April 30, 1992, in Whitefish Bay. Dr Kaufman was born Aug 11, 1948, in Chicago, and graduated from the University of Illinois College of Medicine. His residencies in pediatric surgery were

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completed at Loyola University Medical Center, and Children's Memorial Hospital in Chicago. He was a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Patricia; and four sons, Andrew Daniel, Nicholas, and Peter, of Whitefish Bay.

Harry H. Larson, MD, 67, of Ashland, died May 9, 1992, in Ashland. Dr Larson graduated from the University of Wisconsin Medical School-Madison, and served his internship at St Luke's Hospital in Duluth, Minn. He practiced medicine in Rice Lake and Grantsburg and returned to Ashland in 1957. He was on the medical staff of the Bayfield County Memorial Hospital and also was a member of the American Academy of Family Physicians. Surviving are his widow, Geraldine; two daughters, Barbara Vogel, of St Charles, Ill; Mary Beth, of Madison; four sons, H. Marc, of Green Bay; Scott, of Aurora, Ill, William, of Ashland, and Jeffrey, of Seal Beach, Calif.

Neil A. Lerner, MD, 41, of Shorewood, died May 9, 1992, in Shorewood. Dr Lerner was born Sept 13, 1950, in Brooklyn, NY, graduated from the Medical College of Wisconsin in Milwaukee, and served his residency at Milwaukee County General Hospital. Dr Lerner had his medical practice in Milwaukee for the past 15 years. He was a fellow in the American College of Physicians, and a member of the Medical Society of Milwaukee County, the SMS, and the AMA. Surviving are his widow, Mary; one daughter, Shanna, and two sons, Benjamin and Seth.[150th]

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The *indicates members of the SMS.

March 1992

Abujamra, Fawzi N., Green Bay
* Behling, Ronald E., Madison
* Caya, James G., Burlington
* Chen, Hong Mo, Marshfield
* Cromer, Robert W., Antigo
* Effenhauser, Manfred
* Garvida, Cesar A., Manawa
* Hamilton, Gurcon H., Marshfield
* Han, Paul Zung-Ying, Wausau
* Jeffries, Donald A., Shawano
* Jessen, Kevin A., Tomah
* Johnstone, Michael F., Milwaukee
* Kaupie, Robert C., Wausau
* Klink, Bruce L., Milwaukee
* Kraegel, John H., Wauwatosa

Krause, Justin G., Wausau
* Kurtz, Jeffrey A., Schofield
* Laabs, John E., Neenah
* Larson, David L., Milwaukee

Laughlin, Kathleen M., Madison
* Lechmaier, Timothy E., Madison
* Lemon, Richard A., Middleton
* Lingen, Thomas A., Cumberland
* Lorenz, Frederick S., Burlington
* Matloub, Hani S., Milwaukee
* McDevitt, William P., Milwaukee
* McDonald, Donald H., Winneconne

Moede, Jesm G., Reedsburg

Newton, Carolyn G., Kenosha
* Nogler, Calvin D., Pound

Novak, Dorothy A., Hayward

Poley, Carl R., Green Bay
* Rose, Quentin F., Milwaukee
* Rosenthal, Barbara L., Montello

Rozario, Nirmala J., Milwaukee

Sammour, Mohammed A., Tomah
* Shack, James B., Racine

Smith, David R., Plymouth
* Starr, Robert A., Viroqua
* Woeste, David M., River Falls
* Wong, Walter, Racine
* Kurtz, Jeffrey A., Schofield

April 1992
* Biehl, Mark D., Waukehsa
* Bruckman, James E., Milwaukee
* Chilinski, Steven G., Janesville
* Coleman, Edward J., Green Bay
* Cooper, Ronald J., Waukesha
* Gagrat, Dinshah D., Wauwatosa

Gladieux, John R., South Milwaukee
* Grotenhuis, Paul W., Rhinelander
* Knuteson, Edward L., Monroe
* Laing, Robert E., Racine
* Longstreth, Charles R., Ashland
* Peterson, Robert L., Waupaca
* Rammer, Martin A., Sheboygan
* Rankin, James J., Brookfield
* Rizzo, Michael J., Kenosha

Roh, Byung L., New Berlin
* Swanson, Brian C., Superior

Taclob-Tiu, Lou D., West Allis
* Ullrich, Peter H., Eau Claire

Workman, Barbara E., Redgranite
* Zirneskie, Joseph D., Middleton[150th]

Correction

The contents page of the June *Wisconsin Medical Journal* incorrectly identified Jonathan Tempte, MD, as the author of the *Voice of the SMS*. The *WMJ* regrets the error.

Saga of SMS secretaries

The force of his own merit marks his way.
–William Shakespeare

To serve as the layman executive officer of a professional organization for physicians is a challenge few would be capable of fulfilling–and a daunting responsibility even fewer would accept. In fact in the history of organized medicine in Wisconsin only four individuals have earned their place at the Board table. Each of these men has employed a different set of tools to accomplish the tasks at hand. Each individual has had to prove his mettle. Yet in the final analysis, each executive officer of the SMS has shared a common attribute: each has revealed an intense dedication to the job fueled by a genuine sense of caring for physicians and citizens of the state. Here are their stories in brief.

J. George Crownhart, the first SMS secretary.

Charles H. Crownhart, the second SMS secretary.

J. George Crownhart

Described as a quiet man, Jesse George Crownhart, known as "George" to his colleagues and friends, devoted 18 years to the secretaryship of the state medical society. World War I interrupted his studies at the University of Wisconsin, but Crownhart returned to Madison and graduated with a bachelor's degree in 1921. For 2 years, he was a writer for the largest news service operating at the Capitol, serving more than 30 papers.

Crownhart became the first full-time secretary of the SMS in 1923. He brought to his new position a journalist's inherent desire to change public attitudes through mass education and public access to information.

"George Crownhart came with a new idea. The people must be educated. He proposed to spread light into dark places. To do this, he established a weekly news service to the dailies of Wisconsin; he inaugurated a radio service; he sent the physicians of the state to public meetings to discuss health proposals. He offered his own brilliant talents to all audiences that would listen. That policy of enlightenment helped to renovate the health laws of the state," wrote Wisconsin lawyer, publicist, and historian Fred L. Holmes remembering Crownhart's many contributions.

Crownhart added the duties of secretary of the Wisconsin Hospital Association to his list of responsibilities in 1930 and held both posts until 1937. His tenure at the SMS saw passage of such public welfare milestones as the basic science law which set for the first time a measure assuring the public that those professing to treat the sick possess a basic knowledge of anatomy, pathology, diagnosis and physiology; the first medical grievance committee; the lye-labeling act; and restraints on quackery.

Holmes said Secretary Crownhart's greatest contributions came in his last 5 years of office, when the question of socialized medicine rose to the center of the political arena. The SMS sent Crownhart to Europe to study the situation there and make recommendations. In the ensuing months of observation, Crownhart became convinced that socialized medicine as practiced in Europe would lower the health and medical standards in the nation. "He answered the inquiring call of Wisconsin people who wanted to hear the facts. That report and those addresses robbed socialized medicine of its socialized frenzy," Holmes wrote.

Crownhart died suddenly June 5, 1941, while attending an AMA meeting. He was succeeded by his brother.

Charles H. Crownhart

After serving as an apprentice of sorts to his brother for 18 years, Charlie Crownhart took to the secretary's seat like a duck to water. Life was hectic and confusing in the early days of World War II, but Crownhart, who was trained as a lawyer, embraced the challenge. Crownhart was on the road more often than not as this *Wisconsin Medical Journal* excerpt attests:

"He has had one meal at home in the last 10 days. He has attended 13 state and county ... meetings of physicians all over Wisconsin during the same period. He has

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Earl R. Thayer, the third SMS secretary.

Thomas L. Adams, CAE, the fourth secretary and current executive vice president.

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written letters, arranged discussions, participated in conferences ... traveled hundreds of miles, thought about medicine." That 1942 schedule rings familiar to many involved in organized medicine today.

In his 29 years of service, Crownhart saw many changes in health care technology and delivery. D.N. Goldstein, MD, wrote in 1970 that Crownhart "identified so closely with the problems and aspirations of the medical profession that it is easy to forget that Charlie was educated as a lawyer and not a physician."

At the end of his SMS career, Crownhart headed a staff of more than 550 workers. He supervised the Wisconsin Physicians Service and was managing editor of the *Wisconsin Medical Journal.*

Crownhart was a strong supporter of the Charitable, Educational and Scientific Foundation of the SMS and the Fort Crawford Medical Museum in Prairie du Chien.

Lauding Crownhart for his foresight, the *WMJ* recorded, "Without Crownhart's vision and its implementation, our own society would be a dispirited, listless group, engaged in meaningless, carbon-copy activities of national medical groups. That we are uniquely a *Wisconsin* society is a tribute to Charlie Crownhart's vision and efficiency as a dedicated administrator of our society."

Crownhart retired from his SMS post in 1970.

Earl R. Thayer

World War II may have been over when Earl Thayer arrived at the SMS, but the war stemming from the rivalry between the SMS and the Medical Society of Milwaukee County was still heating up. At issue was health insurance as newly launched insurance companies Wisconsin Physicians Service and Milwaukee County's Surgical Care-Blue Shield competed for subscribers.

Thayer was hired as a publicist in 1947 to promote the SMS and its fledgling insurance arm, Wisconsin Physicians Service. Thayer was beginning a career in organized medicine that would span nearly 4 decades.

A native of Palmyra, Thayer graduated from the University of Wisconsin in 1947 with a Bachelor of Science degree in journalism and that same year was appointed SMS director of public information. He was named assistant secretary in 1954 and served in that position except for a 5-year break in the mid 1960s when he left to run an insurance agency in Waterloo, Iowa. He succeeded Charles Crownhart as the Society's third full-time executive in 1971.

As secretary, Thayer saw more changes in medicine than many had dared dream. In 1947, there were no HMOs, PPOs, no artificial joints or CAT scans. When he joined the SMS, nine people made up the entire staff. During the WPS years, Thayer had management responsibility for 780 employees.

Described as cheerful and unflappable by those who worked with him, Thayer was ready to face any crisis. And there was no shortage of hectic situations. Under his leadership, the medical society faced the malpractice crisis, HMOs and Medicare payment freezes.

As secretary, Thayer was a strong advocate of public health issues and served for 15 years on the state's Health Policy Council. He has remained interested in organized medicine since his retirement in 1987 and is writing a history of the medical society.

Wanted: unforgettable characters

As part of the introspection and reflection that comes naturally to an organization turning 150 years old, the *Wisconsin Medical Journal* would like to feature the colorful, the admirable, and the unforgettable physicians of Wisconsin. If you know of a physician who you think may merit being featured in the *WMJ*, drop us a line telling us who and why. Or, if you prefer, write the story yourself and submit it for consideration. We can't promise to feature everyone suggested, but we'll strive for a good sampling. Write to: "Historical Profiles" *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.[150th]

Thomas L. Adams

Tom Adams took the helm of the SMS in 1987 after a year's transition (an act of the SMS House of Delegates changed the title from secretary to executive vice president in 1992).

Adams started his career in Washington, DC, working as staff to a senator and US representative. He worked at the Appalachian Regional Commission in Washington, DC, for a year then in 1978 turned to the field of organized medicine as director of the Department of Government Affairs for the North Carolina Medical Society. He was lead lobbyist there and directed public relations initiatives. During his tenure, the NCMS was cited by members of the legislature as one of the most effective lobbys in the state house.

In 1983, Adams became director of the Office of Governmental Affairs of the American Society of Anesthesiologists in Washington, DC, establishing an office there for the 20,000-member professional society and directing activities.

Energetic, affable and direct, Adams has won the respect of physicians and staff. Like Thayer before him, Adams has had to meet the challenges born of crisis. Medical malpractice issues, problems with access to health care and increased governmental regulation are areas of concern to organized medicine today. Programs like PartnerCare have helped address the needs of Wisconsin citizens and the SMS has worked with various other state agencies and organizations to develop, "Operation Reform" a 12-point plan for health care reform. The SMS recently formed a task force, at Adams' urging, to develop a plan for Wisconsin future health care system. In 1989, Gov Thompson appointed Adams to the State Health Insurance Pilots Council (SHIP), which he served as chair.

Public health issues continue to be a priority for the SMS and the executive vice president has worked with physicians to see their concerns are addressed by state legislators.

The chapters of SMS history chronicling the contributions of Tom Adams are far from finished. But judging from the political tide of the times, challenge will never be a stranger to the executive officer of the SMS.

A glimpse into our past

Richard D. Sautter, MD, *medical editor*

33 years ago

Infant stages of Medicare. After completing 2 full years of operation, statistics were released for Medicare–a program then administered in Wisconsin by the SMS to serve dependents of military personnel. In Wisconsin, $416,000 was paid on nearly 5,800 claims during 1958, an increase of $133,000 from the program's first year. Obstetrical care accounted for 50% of services. How many Medicare patients would it take today for claims to total $416,000?

Lecture series. Both the William Beaumont and the William Middleton lecture series were founded in 1959. Dr Middleton found himself in the unusual circumstance of having a lecture series named after him while he was still alive and becoming the first speaker in that lecture series for the Wisconsin Society of Internal Medicine, of which he was a member. "If I appear to be speaking to myself, I know you will understand...," he quipped, remarking on the irregularity of the honor.

'You're on your own for the *vim* quotient.'

63 years ago

MEB hires first full-time investigator. At a special meeting of the State Board of Medical Examiners applicants were interviewed for the newly approved position of investigator. "The investigator will be a full-time *man* (emphasis added) whose business it will be to obtain evidence against gross cases of fraud and quackery in the field of the healing art of Wisconsin. This investigator was authorized when Gov Kohler signed the bill providing the board with a sum of $5,000 a year for the next 2 years for this purpose," *WMJ* reported.

Hot times on the way to the AMA. A Menomonie physician, F. E. Butler, MD, traveling to an AMA meeting in Portland had purchased a new Packard for the trip. "Just west of Butte, it was noticed that the engine seemed to be missing but nothing could be found wrong. A few minutes later, it burst into flames. The personal effects of the family were saved but the car burned into a twisted mass while the occupants watched at a safe distance," the *WMJ* brief related. Wonder how the car would have made out on a crash test.

93 years ago

Attorney warns docs: Welcome, but don't drink the water. As the 53rd annual session of the SMS convened, the mayor of Oshkosh, the Honorable J.H. Merrill, invited physicians to avail themselves of the wonders of his city. "We have everything here to suit everybody. We claim to be a cosmopolitan city and a city that is broad-gauged and liberal. Every proper sentiment here is respected ... We have

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breweries and we have a saloon or two, 40 or 50 soda-fountains and 50 public drinking-hydrants. Our water supply has been investigated by an expert lately, and you take it at your peril! *Caveat emptor...*" It's nice to know an attorney was so concerned about physicians' welfare.

We should note that the SMS was not caught unaware by this predicament. "You've been told by the mayor the Oshkosh water is dangerous. The Arrangement Committee has made provision to guard against that by ordering some of the celebrated Milwaukee product," the president announced as the meeting commenced.

Seeking excellence in science. To allow time for more thorough discussion, Society members voted to limit the number of papers presented at the annual session to 20 papers by invitation and 10 "volunteer papers." This was a reduction from the 1889 session policy limiting presentation to 50 papers. In those days "volunteer papers" were submitted unanimously to the Program Committee 4 weeks in advance of the annual meeting. Authors were identified through a separate missive to the Secretary. "It is hoped that members of the Society will enter into this new departure with enthusiasm and with *vim,* and that the next meeting of the Society will be characterized by a high standard of excellence in every department of work," the SMS president noted. Nearly 100 years later, the Editorial Board continues to set a high standard for our science. We hold our authors to the excellence requirement but you're on your own for the *vim* quotient.[150th]

Physicians Insurance Company of Wisconsin: state of the corporation

In many ways, the Physicians Insurance Company of Wisconsin (PIC) has experienced a remarkable year. It has enhanced the value of its stockholders' shares for the fifth consecutive year. It has analyzed and reorganized its operational structure to more effectively serve its policy holders. And, it has prepared for fundamental and unprecedented change: Change that is necessary to meet the challenges generated by trends in the marketplace and by pending regulatory conditions; and most importantly, change that its officers say will distinguish PIC-Wisconsin from its peers and position the company for growth today and in the years to come.

PIC is adjusting its methods to make the most of its ability to serve its policy holders and shareholders: it has reorganized to give more authority to those working most closely with policy holders; it has developed new products and programs based on feedback from its insured; and it has moved to diversify to enhance share value and increase the company's financial stability.

PIC's entry into the dental market signifies this effort to successfully diversify. This strategy broadens its financial base and increases its profit potential, offering another vehicle for growth. It also protects its insured and investors, making the company less vulnerable. A diversified book of business will only strengthen value in the event that shares become available on the open market.

PIC is finishing plans for reorganizing internal operations into "mini-companies" that will streamline its business. The mini-company concept groups specialists who serve a particular product line–underwriters, claims representatives, product development specialists–and allows them the freedom to make decisions that directly affect how they serve their clients.

The mini-company is a unique and intentionally unconventional way of serving PIC's insured, yet the model is believed to be superior to the traditional hierarchical organization common within the insurance industry, because it encourages more creative and responsive decisions by those who work most closely with policy holders.

PIC is also enhancing its advanced data management system. This cutting-edge optical imaging and open architecture computer technology will give employees, agents, and policy holders immediate–yet secure–access to critical information. With these advantages offered by these tools, PIC's officers hope to improve PIC's ability to anticipate and respond to changes in the marketplace.

Officers of PIC say they believe the company's recent accomplishments verify its ability to react responsibly to the demands of change. A new insuring program for large clinics, a hospital insurance program, expanded risk management services and a physicians office insurance product are all under development to take advantage of the vitality being generated by the reorganization, as well as the creativity and abilities of the company's staff.

Strong relationships

The company's partnership with the SMS continues to flourish. PIC representatives have served on important SMS committees, such as the Medical Liability Committee and the Patient Compensation Fund Blue Ribbon Panel, while several SMS members continue to serve on the PIC-Wisconsin board of directors

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PIC's reputation is built on the responsiveness of its staff, as well as of local agents, who specialize in working with insureds to solve problems and explain technical aspects of medical liability insurance. Collaborative efforts with agents continue to improve methods of delivering the best possible service to clients. PIC also relies on task forces, market research and focus groups to elicit salient concerns from agents and policy holders, then uses this information to produce innovative programs designed to address real needs and to determine effectiveness of programs and procedures

Innovations

Out of PIC's many programs and products, its commitment to risk management exemplifies the company's ability to respond creatively to policy holder needs.

In 1991, the company's risk management activities emerged from infancy with a number of highly successful components. Perhaps the most effective and well recognized is the Prenatal Care System, a comprehensive quality assurance plan. It requires specified documentation of care through a patients pregnancy; regular, in-depth patient education sessions; and stringent personnel training to assist in reducing risks. The Prenatal Care System, already successful in several other states, has been well received by Wisconsin physicians, as more than 34% of the eligible doctors are using it.

Recently, the co-developer of the Prenatal Care System, Dr Arnold Greensher, was invited to speak to members of the SMS at their annual meeting. This presentation was co-sponsored by PIC-Wisconsin and SMS Services, Inc, a further indication of PIC's belief in both risk management and building close relationships. PIC collaborated again with SMS on Clinic Manager's Day, which highlights "HIV Issues in Ambulatory Care," shortly thereafter.

PIC-Wisconsin is also proud of its underwriting services. Though it adheres to rigorous underwriting standards, PIC nonetheless attempt to consider policy holders with special needs. Last year, PIC-Wisconsin implemented a creative re-underwriting program, whereby physicians at risk are identified and prescribed individualized risk management procedures. Using this program, PIC's officers hope to work with physicians who have recognizable practice patterns that can be corrected to mitigate incidents which may give rise to claims. Though it will take 2 or 3 years for the process to reach its potential, PIC's officers say that the initial results are very encouraging.

Finances

PIC-Wisconsin continues its steady growth in the medical professional liability market, as more than 200 new physicians became insured from 1990 to 1991, totalling 3,838. By the end of June 1992, an estimated net gain of 130 new physician policy holders was expected.

At the end of 1991, premium volume was more than $25 million, with GAAP retained earnings approaching $22 million, and assets exceeding $94 million. These results confirm PIC-Wisconsin's continued dominance in the medical professional liability market.

Conclusion

PIC-Wisconsin has increased its number of physician policy holders by almost 10% In a market in which it already held a majority of insured, PIC's financial results continue to excel. PIC executed its third consecutive 10% policy holder dividend, while maintaining conservative reserves. And PIC continues to be innovative and pro-active, both within the marketplace and within the company.

The power to overcome.

With a little help from you and a lot of determination, millions of people are now doing some extraordinary things. Like walking, talking and laughing.

Give the power to overcome. Support Easter Seals.

Easter Seals

Millions Victimized by Family Members Every Year!

Are you concerned about the effects of family violence and victimization within your community?

Become an advocate within your community for the prevention of family violence.

Violence among family members has reached staggering proportions. Every year more than 2 million cases of child abuse and neglect are reported, between 2 and 4 million women are battered by their spouses, and between 700,000 and 1.1 million of the elderly population are abused.

The American Medical Association has formed a *National Coalition of Physicians Against Family Violence*. Through the *Coalition* the American Medical Association hopes to involve you in activities that address issues of child abuse, sexual assualt, domestic violence and elder abuse because you have the unique ability to identify the symptoms, first-hand. By joining the *National Coalition* you will be showing your concern about the effects of family violence and victimization, and will become a committed advocate within your community for the prevention of family violence.

Through the *Coalition* you will:

- be informed about local contacts and referrals
- become aware of local and regional resources
- be provided with information regarding model educational programs
- become aware of treatment guidelines and protocols.
- have access to newsletters, public education materials and other publications
- receive an official membership card and frameable poster alerting your patients of your interest in and concern for this problem.

The only **cost** to you **is your commitment** to help curb this problem. Simply complete the membership application form below and mail to the Department of Mental Health, American Medical Association, 515 N. State Street, Chicago, IL 60610.

Yes, include my name in the *Coalition's* membership

Name _____

Address _____

City/State/Zip _____ Telephone # _____

Specialty _____

Auxiliary Member ☐ Yes ☐ No Other _____

Area of interest within Family Violence: ☐ Child Abuse ☐ Sexual Assault ☐ Domestic Violence

☐ Elder Abuse ☐ Other

American Medical Association

Physicians dedicated to the health of America

House actions on resolutions and reports

Resolution 1 pertained to medication reimbursement. The resolution asked that the SMS support efforts for more equitable Medicare medication reimbursement methods to a level reflecting the actual cost of medications to physicians. **Action:** rejected.

Resolution 2 sought support of U.S. House of Representatives bill HR 3393, a measure to address health insurance needs for all children and pregnant women. **Action:** referred to the Board of Directors.

Resolution 3 addressed mandatory malpractice insurance. The resolution directed the medical society to pursue alternatives to current state laws that mandate physicians purchase malpractice insurance. **Action:** rejected.

Resolution 4 urged protection of quality of care for psychiatric patients through discussion with the Wisconsin Hospital Association and hospital credentials committees. The measure resolved that the SMS promote high quality services by appraising the Wisconsin Hospital Association and hospital credentials committee that physicians who collaborate with psychologists must recognize their responsibility for overseeing the medical and psychiatric needs of their hospitalized patients. **Action:** substitute resolution adopted.

Resolution 5 directed the SMS to seek legislation to clarify that the statutory limit on certain damages in wrongful death claim applies to medical malpractice cases. **Action:** rejected.

Resolution 6 addressed equal Medicare reimbursement. This resolution called for the SMS to supports the AMA in developing new strategies to secure equal Medicare payments for services provided by new physicians and to ensure continued patient access to all young physicians. **Action:** adopted.

Resolution 7 pertained to Young Physicians Section membership. The resolution directed each county medical society to specifically designate at least one eligible member to attend YPS meetings at the SMS annual meeting. **Action:** adopted as amended.

Resolution 8 supported mechanisms to address health care costs. This resolution urged mechanisms such as large increases in cigarette taxes to address the health costs associated with smoking with the goal of decreasing cigarette smoking and preventing those disease which are caused or aggravated by smoking. Any additional tax monies should be solely designated for health education and health care services. **Action:** adopted as amended.

Resolution 9 would limit Medicare discrimination against new physicians. This resolution supports efforts to limit the impact of Medicare's discrimination against new physicians and encourages all physicians, at the earliest point possible in their training, to immediately apply for Medicare provider numbers so there will not be as dramatic an impact on their practices as would otherwise occur if they has not already begun the five year period of inequity deemed necessary by Medicare. **Action:** adopted.

Resolution 10 set eligibility requirements for holding SMS office by stating that such positions are limited to physicians active in the practice of medicine, either in patient care or administration. **Action:** rejected.

Resolution 11 created mini-internships to educate non-physicians on medical issues. This plan enlists the SMS Auxiliary in planning and implementing a min-internship program. A test program using a representative rural/urban county medical society should be identified and tested by the 1993 annual meeting. **Action:** substitute resolution adopted.

Resolution 12 addressed the need to compensate internists and cardiologists for interpretation of electrocardiographic tracings. The resolution urged SMS support of efforts at the federal level to restore adequate compensation for interpretation of electrocardiographic tracings by physicians. **Action:** adopted as amended.

Resolution 13 protested low Medicare reimbursement rates for physicians practicing in surgical subspecialties and urges

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SMS communication for legislation to correct this problem that impedes expansion of services. **Action:** rejected.

Resolution 14 pertained to the inability and lack of adequate representation between physicians and the Health Care Financing Administration. **Action:** referred to the Board of Directors.

Resolution 15 directed the SMS to continue to describe to Congress the inequity of Medicare reimbursements for physicians who have just completed their residencies and support legislation to repeal current law that mandates payment reductions for physicians in their first years of Medicare practice. **Action:** Adopted as amended.

Resolution 16 called for the filing of an anti-trust complaint against an insurance carrier for an alleged attempt to establish prices for physician services. **Action:** rejected.

Resolution 17 requested inclusion of more information in *Medigram* on the structure and workings of the Wisconsin Peer Review Organization (WIPRO) including: information on the review process; the selection process for the WIPRO Board; and information regarding WIPRO elections. **Action:** substitute resolution adopted.

Resolution 18 cited the extensive medical costs each year associated with domestic violence and establishes an ad hoc advisory committee focusing on addressing domestic violence through the physician community. **Action:** adopted.

Resolution 19 supported development of an Office of Preventative Health within the SMS for the purpose of developing effective preventative mental and physical health activities for SMS physicians and Wisconsin citizens. **Action:** referred to the Board of Directors.

Resolution 20 referred to legislative proposals, urging efforts to modify state law to allow voters to approve binding referendums. **Action:** rejected.

Resolution 21 addressed inappropriate OBRA guidelines and calls for the SMS to work with DHSS to simplify interpretation, implementation and compliance with the Omnibus Budget and Reconciliation Act of 1987 guidelines for pharmacy and medication use in nursing homes. **Action:** substitute resolution adopted.

Resolution 22 opposed the sale of "true crime" collector cards that glamorize serial killers and other infamous criminals due to their potential impact on children. The resolution urges education of Wisconsin physicians through SMS publications. **Action:** Adopted as amended.

Resolution 23 pertained to indemnification from medical malpractice actions for physicians who assist public health agencies. This resolution directs the SMS and the AMA to work with government to develop immunity from medical malpractice actions for physician volunteers. **Action:** substitute resolution adopted.

Resolution 24 sought to eliminate professional liability insurance premium discounts for Medical College of Wisconsin faculty members. Committee felt this issue is the responsibility off the Patients Compensation Fund Board. **Action:** rejected.

Resolution 25 supported legislation which prohibits the inclusion of local public health departments into human services agencies. SMS policy states that local public health agencies should be full service, distinct, and not incorporated into local departments of human services. **Action:** substitute resolution adopted.

Resolution 26 protested government-mandated health care cost increases. **Action:** rejected.

Resolution 27 urged equity in the law through the elimination of Wisconsin laws mandating physicians have unlimited liability insurance and urges the SMS to seek equal treatment that physicians, like other professionals, can purchase only the insurance that they wish. **Action:** rejected.

Resolution 28 addressed Medical Assistance co-pays. The resolution would reward welfare patient's use of office versus emergency room care by paying welfare patients $5 for each physician office visit and charging them $5 for each emergency room visit. **Action:** rejected.

Resolution 29 referred to mandated payment charges. Directs the SMS to form a committee to receive input from, collect data and review Medicare RBRVS payment changes. **Action:** rejected.

Resolution 30 addressed health insurance policies by mandating that insurance policies list which portions of the payment are going to physicians, hospitals, administration, overhead costs and profit including reserves. **Action:** referred to the Board of Directors.

Resolution 31 urged legislation to require physicians be sent copies of patients' bills to help in identification of hospital overcharges. **Action:** rejected.

Resolution 32 called for the medical society to notify the public about the limitations of the Canadian system of health care delivery and the negative impact such a system, if used in the United States, might have on the population. **Action:** rejected.

Resolution 33 sought to increase public awareness of the high cost of medical malpractice insurance. **Action:** rejected.

Resolution 34 directed a modification of SMS dues between the various Medicare-defined geographic regions. **Action:** rejected.

Resolution 35 required that physicians serving in National Health Services Corps be compensated at a rate similar to those who are not serving in a medically un-

derserved area. **Action:** referred to the Board of Directors.

Resolution 36 bid the SMS to develop guidelines for ethics pertaining to advertisements seen by the general public. The SMS should encourage members to review all advertisements sent out by its administrative branches and encourage physicians to voluntarily eliminate any extreme claims. **Action:** rejected.

Resolution 37 provided that one copy of the compendium of SMS policies be available to each county medical society and various SMS committees and officers. **Action:** adopted as amended.

Resolution 38 requested that the SMS pursue appropriate efforts to address allegedly deceptive claims of board certification as such claims pose a risk to health care consumers. **Action:** rejected.

Resolution 39 sought immunity from medical malpractice actions for physicians who volunteer to help at charitable clinics and programs. **Action:** substitute resolution adopted.

Resolution 40 directed the SMS to strongly encourage the state to promote development of medical school programs to train and encourage medical students to enter careers in general internal medicine, family practice and general pediatrics to meet the needs of Wisconsin citizens. **Action:** substitute resolution adopted.

Resolution 41 called for the SMS to recommend to the Health Care Financing Administration that Wisconsin be reclassified as a single Medicare payment locality to reduce administrative costs associated with multiple payment areas and simplify administrative problems for both government and physicians. **Action:** adopted.

Resolution 42 urged the AMA to work with the National Rifle Association to resolve differences so gun violence in America may be reduced. **Action:** adopted.

Resolution 43 endorsed the Medical Clinic on Wheels, a Wisconsin-based project aimed at providing medical services to people at risk from the Chernobyl nuclear disaster in the Ukraine and encourages SMS members to lend their support. **Action:** adopted.

Resolution 44 supported actions that would limit penalties inflicted by state and federal agencies to those in demonstrable proportion to the harm inflicted and would make all voluntary agreements waiving a citizen's rights invalid if signed under duress such as perceived threat of loss of license, liberty and assets. **Action:** rejected.

Resolution 45 supported improved medical education of county coroners, district attorneys and law enforcement personnel with the goal of enhancing cooperation with physicians in medical-legal problems. **Action:** adopted.

Report A of the Commission on Continuing Education reviewed the work of the commission in the areas of CME and accreditation of hospitals and medical specialty societies within the state. **Action:** filed.

Report B of the Physicians Alliance Commission discussed policy and posi-

Continued on next page

Reference committees: 1992

Socioeconomic activities
Kevin T. Flaherty, MD, Wausau, chair
Charles E. Holmburg, MD, Menomonee Falls
Julie N. Larsen, MD, Waukesha
Thomas L. Schlenker, MD, Milwaukee
Paul H. Steingraeber, MD, La Crosse

Scientific activities
Robert E. Phillips, MD, Marshfield, chair
Carl S. L. Eisenberg, MD, Milwaukee
Carlos A. Jaramillo, MD, Monroe
William J. Maurer, MD, Marshfield
Elizabeth T. Sanfelippo, MD, Fond du Lac
Terry L. Hankey, MD, Waupaca (alternate)

State and national issues
Patricia M. Barwig, MD, Milwaukee, chair
Donald R. Beaver, MD, Elm Grove
Richard W. Edwards, MD, Richland Center
Joseph C. DiRaimondo, MD, Manitowoc
Joseph W. Weber, MD, New London
Mark K. Belknap, MD, Ashland (alternate)

Organization and finances
Paul A. Wertsch, MD, Madison, chair
James D. Buck, MD, Milwaukee
James L. Concannon, MD, Kenosha
Roland M. Hammer, MD, River Falls
Kevin A. Jessen, MD, Tomah

Credentials
Raymond R. Johnson, MD, Wauwatosa, chair
Benjamin C. Wedro, MD, La Crosse
Kathleen M. Wick, MD, Beloit[150th]

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tions of the SMS on state legislative and federal regulatory issues. **Action:** filed.

Report C of the Commission on Mediation and Peer Review summarized the work of the commission in the areas of mediation, peer review, Medicaid auditing, physician health and reviewed the goals of the commission for the upcoming year. **Action:** filed.

Report D of the Commission on Public Information discussed ongoing efforts to educate the public on medical issues. The report provided an update on outreach activities to increase youth awareness of substance abuse, and revision of the physician citizen of the year award program. The commission approved underwriting of health-related programs. **Action:** filed.

Report E reviewed the work of the editorial board of the *Wisconsin Medical Journal* over the last 12 months and discussed a significant increase in coverage of socioeconomic and legislative issues. The report detailed business aspects including the number of scientific papers accepted and rejected as well as outlined objectives for future issues. **Action:** filed.

Report F of the Committee on Aging, Extended Care Facilities and Home Health Care reviewed committee work for the past year concerning new federal and state regulations on cardiopulmonary resuscitation in nursing homes, advance directives and more. **Action: filed.**

Report G detailed the work of the Committee on Alcoholism and Other Drug Abuse including findings on patient placement criteria and recommendations in response to the report of the state Task Force to Combat Alcohol and Other Drug Abuse by Pregnant Women and Mothers of Young Children. **Action:** filed.

Report H of the Committee on Environmental and Occupational Health provided information on the committee's work for the past year including educational programs for physicians on use of existing emergency medical information systems and management of hazardous materials. The report noted the committee has finished updating the Occupational Health Guide. **Action:** filed.

Report I outlined the work of the Committee on Maternal and Child Health. During the past year, this committee explored such issues as school-based clinics, newborn drug testing, alternative prenatal care sites, HIV and pregnancy, and services for children with special needs. The committee also made recommendations in support of expanding rights of foster parents to allow HIV testing. **Action:** filed.

Report J of the Committee on Medicine and Ethics discussed committee review of withholding and withdrawing life-prolonging treatment for nursing home patients. The committee also addressed CPR Practice Parameters for residents in long-term facilities. Over the course of the year, the committee reviewed its title. The end result was a name change, deleting references to "religion." **Action:** filed.

Report K of the Committee on Mental Health details ongoing study of mental health plan benefits including review of a report from the Office of the Commissioner on Insurance regarding costs of mandated benefits in Wisconsin in 1990. The committee also examined the issue of managed care and its effect on treatment services for mental illness. The committee is following developments in practice parameters for psychiatry. **Action:** filed.

Report L related the activities of the Committee on Safe Transportation. The committee studied a resolution outlining a comprehensive plan for the EMS system in Wisconsin, concurring with state findings and recommending change in SMS policy. Other issues included: seat belt use, medically impaired drivers, motorcycle helmet laws and development of a joint safety belt campaign with the state Department of Transportation. **Action:** filed.

Report M of the Committee on Health Care Financing and Delivery reviewed issues including liaisons with outside groups; health care prioritization and discussion of resolutions on waste of medical resources. The committee reported on the workings of the Medical Assistance Technical Advisory Committee. **Action:** filed.

Report N of the Medical Liability Committee discussed issues considered by the committee binding arbitration, the activities of WHCLIP and PCF and ongoing efforts for tort reform. The committee also gave an update on the Physician Support Program, which provides information and peer support to physicians and spouses involved in a medical liability lawsuit. **Action:** filed.

Report O of the Wisconsin Nurses Association/SMS Liaison Committee discusses issues addressed by the committee including managed care, Medicaid and Medicare reimbursement for nurse practitioners and health care reform proposals.
Action: filed.

Report P of the PartnerCare Working Group reported the receipt of the Award of Excellence from the American Society of Association Executives and the decision by the SMS Board to permanently tie the PartnerCare income tax guidelines to the Homestead Tax Credit Program. **Action:** filed.

Report Q of the Medicare Medical Policy Advisory Group reviewed policies for several clinical areas in the past year and pertinent issues including HCFA definitions of surgery terms, use of the new CPT-4 evaluation and management codes, payment for certain drugs and services and site of service reduction for services provided in an outpatient setting. **Action:** filed.

Report R of the secretary detailed the major SMS accomplishments of the past year. Highlights included: publication of a primer on the Resource Based Relative Value Scale; national recognition of Part-

nerCare; SMS involvement in a health care reform coalition and celebration of 150 years of caring for Wisconsin residents. **Action:** filed.

Report S of the Wisconsin delegation to the American Medical Association highlighted AMA positions on federal issues and outlined Wisconsin resolutions brought before the AMA at the annual meeting. **Action:** filed.

Report T of the Board of Directors encompassed the 1992 budget, recommendations for 1993 dues increase; task force report on relationships between medical schools and the medical community; 1991 Resolution 13–section for thoracic medicine; expanded duties of the SMS treasurer and election change; and name change for secretary-general manager. **Action:** adopted.

Report U of the Board of Directors reported on the following topics: 1991 Resolution 21-Peer Review Code of Conduct; 1991 Resolution 31–foster parent rights to medical information; 1991 Resolution 26–reporting of domestic violence; 1991 Resolution 36-detention of domestic violence; 1991 Resolution 3–blood alcohol laws of evidence; 1991 Resolution 7–mandatory binding arbitration; and revision of public health statutes. **Action:** adopted. The report also discussed a section on tort form initiatives; and health care reform initiatives–Operation Reform (12-point plan). **Action:** filed.

Report V of the Board of Directors discussed: the section on the SMS response to RBRVS; Medical Assistance reimbursement; section on OHCI data gathering activities; section on Workers Compensation reasonableness of fees and necessity of treatment. **Action:** filed. The Board report also address a section tying PartnerCare income guidelines to the Homestead Tax Credit; and 1991 Resolutions 17 and 18–Waste of medical resources. **Action:** adopted.

Report W of the Board of Directors covered the following topics: 1991 Resolution 32–hazardous materials exposure; 1991 Resolution 35–comprehensive plan for the EMS system; section on patient placement criteria for treatment of psychoactive substance use disorders; section on alcohol and drug use by pregnant women and mothers of young children; section on HIV-infected health care workers; section on HIV breastfeeding advisory; section on practice guidelines for CPR in long-term care settings; section on school-based clinics; and section on interprofessional code on advance medical directives. **Action:** adopted.[150th]

1993
SMS annual meeting
April 14-17
in
La Crosse

House of Delegates Nominating Committee: 1992-93

District 1
Irwin J. Bruhn, MD, Route 1, Box 64-A, Lakeville Rd, Walworth 53184
Jerome W. Fons, Jr, MD, 3734 W Coldspring Rd, Greenfield 53221
James P. Gierahn, MD, 2405 Northwestern Ave, Racine 53404
Robert F. Purtell, Jr, MD, 3316 W Wisconsin Ave, Milwaukee 53208
John D. Riesch, MD, PO Box 427, Menomonee Falls 53051-0427

District 2
Thomas H. Browning, MD, 20 S Park St, Ste 355, Madison 53715-1348
Sandra L. Osborn, MD, 1912 Atwood Ave, Madison 53704
Jeffrey C. Thomas, MD, 3524 E Milwaukee St, Janesville 53546

District 3
Kevin A. Jessen, MD, 1112 Charles Dr, Tomah 54660

District 4
Robert E. Phillips, MD, 1000 N Oak St, Marshfield 54449, chair

District 5
David R. Weber, MD, 80 Sheboygan St, Fond du Lac 54935

District 6
Rolf S. Lulloff, MD, 2520 Betty Court, Green Bay 54301

District 7
James F. Maser, MD, 912 W Knapp St, Rice Lake 54868

District 8
Joseph M. Jauquet, MD, 2101 Beaser Ave, Ste 2, Ashland 54806

Specialty sections
Carl S. L. Eisenberg, MD, 3003 W Good Hope Rd, PO Box 17300, Milwaukee 53217[150th]

HOUSE OF DELEGATES: 1992

State Medical Society of Wisconsin

Speaker: Richard G Roberts/Vice Speaker: Kenneth I Gold

County Medical Society	Delegate	Alternate
FIRST DISTRICT		
KENOSHA	James L Concannon	Roman Bilak
	Kevin J Fullin	Ernesto E Buencamino
	Charles E Pechous Jr	Ramanuja Rao Manda
	Clifton E Peterson	Michael Zeihen
MILWAUKEE	Albert H Adams	Ashok R Bedi
	Francis I Andres	Fredrik F Broekhuizen
	William H Annesley Jr	Robert P Cronin
	Mark R Aschliman	Susan L Kaehler
	Anthony H Balcom	James P Maney Jr
	Edward N Barthell	Muni H Patel
	Patricia M Barwig	Roger L Ruehl
	Joseph C Battista	Burton A Waisbren
	Donald R Beaver	David E Weissman
	John T Bjork	43 Vacancies
	Gregory B Buck	
	James D Buck	
	Jeffrey J Butler	
	Donna D Davidoff	
	Kevin J Di Napoli	
	Gerald J Dorff	
	Reynaldo P Gabriel	
	Lucille B Glicklich	
	Lawrence A Golopol	
	Gerald G Govin	
	Stephen W Hargarten	
	Donald P Hay	
	Timothy J Hill	
	Raymond R Johnson	
	Brian W Kennedy	
	Christina C Keppel	
	Thomas M Kidder	
	Stanley A Korducki	
	Alvin K Krug	
	Christopher K Kubat	
	Vijay V Kulkarni	
	George M Lange	
	Vincent G Lubsey	
	James A Means III	
	Dean D Miller	
	Robert John Miller	
	John P Mullooly	
	Andrew A Pandazi	
	Robert F Purtell Jr	
	Marcia J S Richards	
	John E Ridley III	
	Thomas L Schlenker	
	George R Schneider	
	Robert H Sewell	
	Paul J Sienkiewicz	
	Frank H Urban	
	Wess R Vogt	
	James P Volberding	
	Gerald W Wadina	
	John E Whitcomb	
	DeLore Williams	
	Carol E Young	
OZAUKEE	Arthur B Conrad	Gregory J Gnadt
RACINE	Barry M Altenberg	S Marshall Cushman Jr
	Victoriano A Baylon	Dennis E Feider
	James P Gierahn	Kenneth J Pechman
	Marvin G Parker	David R Zeman
	Raymond E Skupniewicz	2 Vacancies
	Vacancy	
WALWORTH	Irwin J Bruhn	Edsel G Doreza
WASHINGTON	Charles S Geiger Jr	William J Listwan
	Michael C Reineck	Thomas E Looze
WAUKESHA	LaVern H Herman	Brian A Chapman
	Charles E Holmburg	John J Foley
	Julie N Larsen	Terrence N Hart
	Timothy G McAvoy	Thomas A Hofbauer
	G Daniel Miller	Karin Kultgen
	Michael G O'Mara	Kraig E Lorenzen
	John D Riesch	Dean L Martinelli
	Jay F Schamberg	Matthew A Meyer
	James A Stadler II	John R Park
	Lee M Tyne	Gwendolyn Tanel

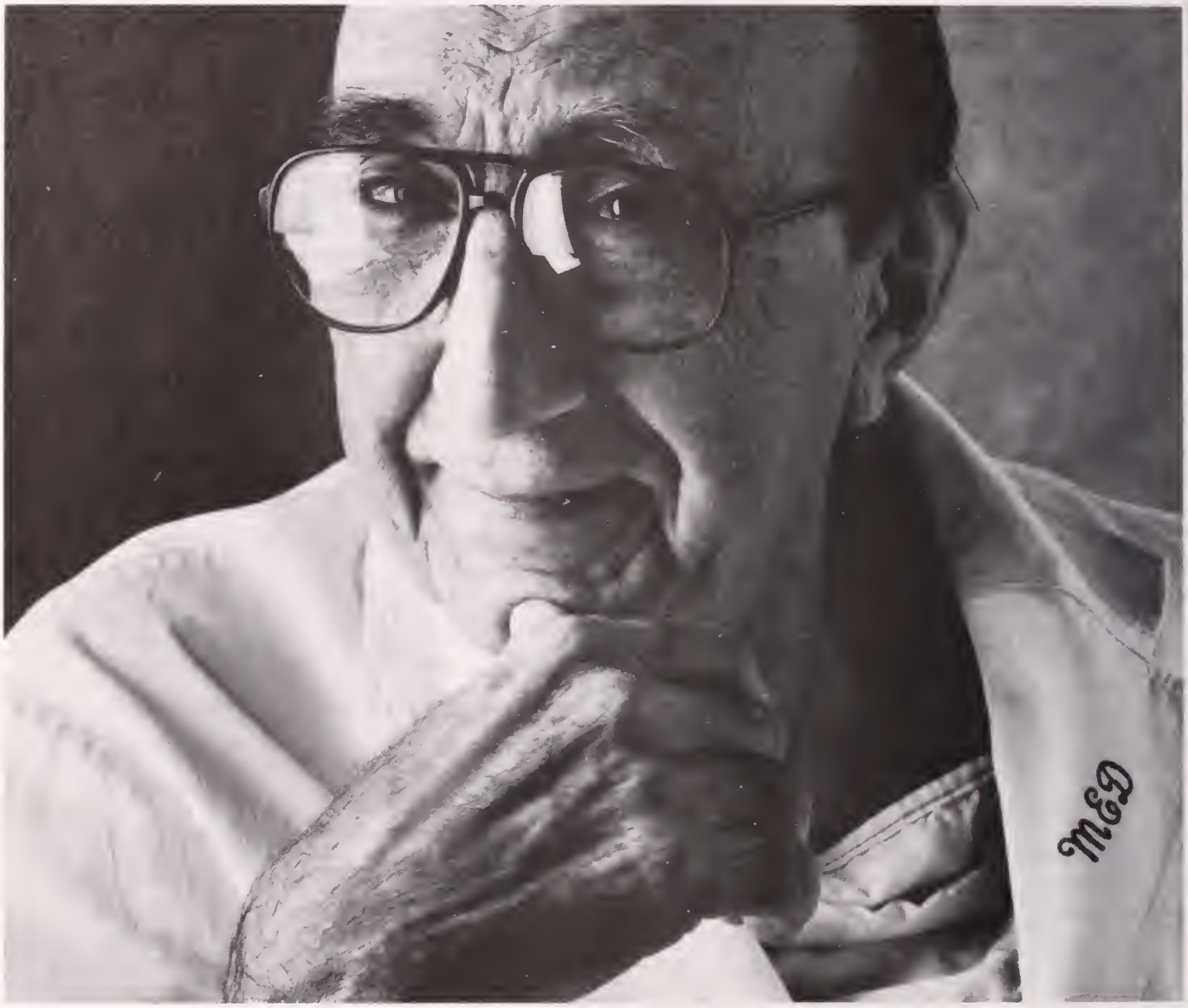
County Medical Society	Delegate	Alternate
SECOND DISTRICT		
COLUMBIA-MARQUETTE-ADAMS	Robert T Cooney	Martin L Janssen
DANE	Adam H Balin	Kenneth T Bastin
	Gary R Bridgwater	Vernon N Dodson
	Thomas H Browning	James E Engeler Jr
	Dolores A Buchler	Stefan Gravenstein
	Raymond W M Chun	Judith N Green
	Andrew B Crummy Jr	Lewis B Harned
	Peter L Eichman	Vernon B Hunt
	Kenneth Felz	Susan N Isensee
	Haywood S Gilliam	John D Kenny
	Kay A Heggestad	Ivan Knezevic
	Kay E Jewell	George M Kroncke
	William L Kopp	Paul A Mc Leod
	Richard D Lindgren	Bernard F Micke
	Bradley L Manning	Kathryn P Nichol
	Sandra L Osborn	Joseph F Sackett
	John K Scott	Alan I Schwartzstein
	Robert B Shapiro	Nancy J Selfridge
	Richard L Staley	Armond H Start
	Benton C Taylor	Roland J Vega
	Marc D Tumerman	John A Vukich
	Ronald D Wenger	John D Wegenke
	Paul A Wertsch	Richard O Welnick
DODGE	Ayaz M Samadani	M Ahmad Ali
GRANT	Charles L Steidinger	Vacancy
GREEN	Jan E Erlandson	William E Hein
	James C Pollock	David C Riese
IOWA	Harald P L Breier	Timothy A Correll
JEFFERSON	George L Gay Jr	Michael A Grajewski
LAFAYETTE	Robert J Bernardoni	Lori L Neumann
RICHLAND	Richard W Edwards	Thomas L Richardson
ROCK	Paul F Durkee	Ronald K Bowers
	Jordon Frank	Leland J From
	Larry M Ojeda	Rodrigo Merino-Roldan
	Jeffrey C Thomas	David C Murdy
	Kathleen M Wick	Diana L Wright
SAUK	John A De Giovanni	Donald W Vangor
THIRD DISTRICT		
CRAWFORD	Michael S Garrity	Vacancy
JUNEAU	Vernon M Griffin	David M Hoffmann
LA CROSSE	Thomas J Grau	William A Agger
	Michael H Mader	Terry D Benson
	Paul H Steingraeber	Wayne A Bottner
	Benjamin C Wedro	Christopher M Huiras
	Edward R Winga	Paul J Leehey III
	Robert S Witte	Charles E Link
MONROE	Kevin A Jessen	Edward O Lukasek
TREMPEALEAU-JACKSON-BUFFALO	Jeffrey K Polzin	Elmer P Rohde
VERNON	Mark H Andrew	Timothy J Devitt

County Medical Society	Delegate	Alternate
FOURTH DISTRICT		
CLARK	Paul L Writz	Alfred R Talens
FOREST	Burton S Rathert	E Frank Castaldo
LANGLADE	Michael J Reinardy	James O Moermond Jr
LINCOLN	Orlando M Francisco	Paul A Thompson
MARATHON	Kevin T Flaherty	Kathy P Belgea
	Jeffrey H Lamont	Joel R De Koning
	William C Miller	Norman F Deffner
	Gerald H Schroeder	Thomas O Miller
	Vacancy	Vacancy
ONEIDA-VILAS	Paul W Grotenhuis	Gary A Peitzmeier
	William E Raduege	Paul K Wegehaupt
PORTAGE	Daniel L Brick	Robert J Jaeger
PRICE-TAYLOR	Michael A Haase	William E Yanke
WOOD	Louis C Hacker	John D Adolphson
	William J Henry	Ali K Choucair
	Michael J Kryda	Ade R Dillon
	William J Maurer	W Bruce Fye
	Michael P Mehr	Gurdon H Hamilton
	Robert E Phillips	Mario V Ponce
	Theodore A Praxel	John E Thompson
	Homer H Russ	Vacancy
FIFTH DISTRICT		
CALUMET	William E Hannon	Badri N Ganju
FOND DU LAC	Brian C Christenson	K Alan Stormo
	Elizabeth T Sanfelippo	Jeffrey A Strong
	David R Weber	Vacancy
GREEN LAKE-WAUSHARA	Alan L Taber	Jeffrey J Carroll
OUTAGAMIE	Jan C Bax	George A Behnke
	Henry Chessin	4 Vacancies
	Charles F Dungar	
	Peter V Podlusky	
	Vacancy	
WAUPACA	Joseph W Weber	Lloyd P Maasch
WINNEBAGO	James L Basiliere	6 Vacancies
	James E Cauley	
	Albert L Fisher	
	Johan A Mathison	
	Kevin F Quinn	
	Vacancy	
SIXTH DISTRICT		
BROWN	James M Berner	Bruce C Bressler
	Robert K De Mott	Timothy J Freeman
	Stewart W Gifford	Kenneth M Kubsch
	Rolf S Lulloff	5 Vacancies
	Wesley E Mc Neal	
	Edwin S Watts	
	2 Vacancies	
DOOR-KEWAUNEE	John J Beck	Michael R Mc Fadden
MANITOWOC	Edward J Barylak	Thomas K Perry
	Joseph C Di Raimondo	Joseph E Trader
MARINETTE-FLORENCE	John E Kraus	Vacancy
OCONTO	William J Wittman	James J Wallace
SHAWANO	Ronald L Harms	Vacancy
SHEBOYGAN	Robert J Freedland	Roger G Klettke
	Kevin S Myers	James R Pawlak
	Wendelin W Schaefer	Vacancy

County Medical Society	Delegate	Alternate
SEVENTH DISTRICT		
BARRON-WASHBURN-BURNETT	James F Maser	Douglas J Raether
	Donald E Riemer	William A Smith
CHIPPEWA	Caesar R Gonzaga	Vacancy
EAU CLAIRE-DUNN-PEPIN	Steven G Brown	Robert J Fabiny
	Philip J Happe	Edgar O Hicks
	Daniel F Johnson	3 Vacancies
	Henry J Simpson	
	Vacancy	
PIERCE-ST. CROIX	James R Beix	Roland M Hammer
POLK	John O Simenstad	William W Young
RUSK	Douglas M De Long	Vacancy
EIGHTH DISTRICT		
ASHLAND-BAYFIELD-IRON	Mark K Belknap	John C Oujiri
DOUGLAS	Robert L Sellers	Vacancy
SAWYER	Lloyd M Baertsch	Paul Strapon III

SECTIONS	Delegate	Alternate
Allergy & Clinical Immunology	Donald A Bukstein	Steven H Cohen
Anesthesiology	Warren J Holtey	Gregory A Felsheim
Cardiology	A Daniel Harbin	Robert M Green
Dermatology	Donald J Miech	Stephen E Hoy
Emergency Medicine	Peter J Holzhauer	Dean T Stueland
Family Physicians	Terry L Hankey	Thomas H Peterson
Hospital Medical Staff	Stephen R Peters	Louis R Pfeiffer
Internal Medicine	Susan L Turney	Richard A Dart
International Medical Graduates	Carlos A Jaramillo	Morgan E Warffuel
Medical Faculties	Vacancy	Vacancy
Medical Students	Michael W Bigelow	Donald J Anderson
Neurology	Gamber F Tegtmeyer Jr	R Clarke Danforth
Neurosurgery	Glenn A Meyer	Vacancy
Obstetrics-Gynecology	Michael A Schellpfeffer	Dennis A Sobczak
Ophthalmology	M Thomas Chemotti	Gregory P Kwasny
Orthopedics	James A Rydlewicz	James H Langenkamp
Otolaryngology	Glenn M Seager	Thomas W Grossman
Pathology	Ronald R Martins	Raymond C Zastrow
Pediatrics	Carl S L Eisenberg	Vacancy
Physical Medicine & Rehabilitation	Ram Parvesh Bhala	Keith B Sperling
Plastic Surgery	Harvey M Bock	Andrea S Doermann
Preventive Medicine	Vacancy	Jane K Sliwinski
Psychiatry	Rudolf W Link	Pauline M Jackson
Radiation Oncology	Sally M Schlise	Robert H Greenlaw
Radiology	Timothy T Flaherty	Vacancy
Resident Physicians	Jean M Loftus	Vacancy
Surgery	James P Quenan	Louis C Bernhardt
Urology	Stuart W Fine	Charles W Troup
Young Physicians	Gary L Bryant	Peter S Foote

Join Dr. DeBakey.



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"This is a time when we need a unifying force in the medical profession very badly.

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Join Dr. Michael E. DeBakey, Chancellor and Chairman, Department of Surgery, Baylor College of Medicine, in the AMA. Call this toll-free number now.

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American Medical Association

Presidential address

Health care reform's future: the road less traveled

Cyril M. "Kim" Hetsko, MD, Madison

It's now been 151 years since the Legislature of the Wisconsin Territory first chartered the State Medical Society of Wisconsin. At that time in 1841, the Wisconsin Territory consisted of what is today the state of Wisconsin, plus the states of Iowa, Minnesota, and those parts of the Dakotas generally east of the Missouri river. This was also just a decade after Dr William Beaumont did some of his pioneering work on the mysteries of digestion with Alexis St Martin at Fort Crawford in Prairie du Chien, Wisconsin. In 1841, diseases such as smallpox, cholera and malaria were very serious epidemics in this area. Clearly, a lot has happened in the intervening years since our founding to bring us to today.

Down through the years, from the time of Dr Beaumont, Wisconsin has been blessed with many pioneering physicians such as:

- Dr Mason Darling, of Fond du Lac, one of the SMS founders;
- Dr Thomas Steel, who obtained small pox vaccine from relatives in England in 1846, to help stem an epidemic in Wisconsin;
- Dr Nicholas Senn, of Fond du Lac County and Milwaukee, president of this society in 1879, who helped bring the lessons of sterile surgical techniques to physicians around the world;
- Dr Charles Oviatt, of Oshkosh, who developed new abdominal surgical techniques in the later 19th century;
- Dr Mary Sorenson, of Polk County, who from the 1880s into this century, was a pioneering woman physician;
- Dr Cornelius Harper, the public health officer of Wisconsin from 1911 to 1943 who spearheaded special TB hospitals, disease prevention, and needed public health laws; and
- Dr William S. Middleton, whom I was honored to have worked with in his later years, who was founding Dean of the University of Wisconsin Medical School, a giant in medical education, and chief medical consultant in the European Theater during World War II.

Cyril M. "Kim" Hetsko, MD, SMS president: 1991-1992

These colleagues, plus unsung thousands of other physicians, both past and present, have combined the best of the art of medicine with the science of medicine for the citizens of Wisconsin.

I have been honored to be your president over the past year. If one looks at the SMS constitution and bylaws, the SMS president is called the "chief constitutional officer," but in delineating the duties, the bylaws in reality give your president the role of chief cheerleader. The duties outlined in the bylaws are to give this annual speech to this House,

Continued on next page

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serve on the SMS Board and chair its Executive Committee; participate without vote in the deliberations of this House; initiate, propose, support and articulate SMS policies and programs; and promote physician participation in the SMS.

As your president, I have had a number of significant experiences over the past year, including meetings with members of the US Senate and House about federal health legislation and policies, and at the state level, meetings with Gov Thompson and state legislators about state health problems. This was done to try to convey your concerns about the health and well being of the citizens of our great state. Additionally, I've taken your messages to the governmental administrators, including federal HHS Secretary Dr Louis Sullivan and HCFA Administrator Gail Wilensky, now a White House adviser. Lest I forget, I've also interacted on your behalf with the print and broadcast media to try to convey your concerns.

Besides representing you, along with the rest of the Wisconsin delegation, at the AMA House of Delegates, I also acted as the SMS ambassador to the annual meetings of our sibling societies in Minnesota, Nebraska, Ohio, South Dakota, Indiana, Michigan and Illinois, and I convey to you their best wishes. Another duty for me as your president this past year, was to serve on the search committee for a new dean at the UW Medical School. I even presented some of your policy views before a committee in Chicago of that other professional organization, the American Bar Association.

But, by far the most important and satisfying part of the past 12 months for me, has been my meeting with individual Wisconsin physicians. I've been lucky enough to attend the meetings of almost half of our 55 county medical society meetings and several specialty society meetings. I am most impressed with you, the physicians of Wisconsin, and your unswerving dedication to building access to high quality health care for our citizens. You, the individual Wisconsin physicians, are indeed the real leaders of our organization. I salute you.

As I complete my year as president of your Society, I would like to reflect for a moment on the health of our state today.

What is the current status of the health care system in Wisconsin in 1992? We most certainly have problems of unevenness of health care; for example, at least 9 of 72 counties have no obstetrical services; we need by one estimate at least 150 more family physicians to meet current needs; and more and more of our rural areas, as well as our central cities, lack needed physicians and hospitals. While the health status of Wisconsin's residents as a whole is enviable, there are many who do not share this good fortune, due in part to lack of access to good health care. Low birth weight babies, high infant mortality rates in some populations, and unimmunized children all remind us of how much more needs to be done.

Currently, however, cost containment has apparently gained the upper hand over access in the health care reform debate. In Wisconsin, over the past decade, a number of programs have been developed to control costs, including HMOs, IPAs, PPOs, self-funded ERISA plans, employer buying groups, and various other so-called managed care arrangements.

Recent rapid growth has been noted in the use of self-funded plans by employers to cover their employees, but under federal ERISA laws such plans are exempt from oversight by the states. These plans are essentially unregulated in terms of benefits offered, fiscal solvency, market conduct, changes in benefits, and payment of claims. These plans are also exempt from contributing to the state's high risk health insurance pool for those who are otherwise unable to obtain health insurance.

For both self-funded plans and state-regulated insurance, cost containment desires have often led to: the elimination from the plan of those with pre-existing conditions; reduction or elimination of coverage for various conditions; the loss of long-term benefit portability in the event of a job change or a disability; and high premium increases, especially for those with serious health problems.

For physicians, a 600% increase in professional liability insurance costs over the past decade and the costs of defensive medicine brought on by a tort system out of control have further escalated the costs of providing health care.

Wisconsin physicians, it must be noted, have continued their tradition of seeking to assure that no person goes without health care because of financial or other concerns. Programs such as ShareCare, WisconCare, and PartnerCare, participation in Medical Assistance, and the numerous unsung individual acts of compassion and charity stand as testimonial to this. More than 80% of our numbers participate in PartnerCare, which accepts Medicare payments as full payment for care for those over 65 years old and having incomes less than $19,154.

A study published last year documented that the average Wisconsin physician provides more than $20,000 per physician in under- or uncompensated care per year just for those under age 65.

In spite of being subjected to a number of undermining forces, the Wisconsin health care system has functioned fairly well–frequently due to the efforts of Wisconsin's physicians. National health statistics have shown Wisconsin to have among the nation's lowest infant mortality rates and longest life expectancies. Insurance industry rankings have rated the overall health of Wisconsin citizens as among the best in the country.

Even a study by the Public Citizen Health Research Group (which advocates a Canadian-style universal health plan) points to Wisconsin as having one of the lowest percentages of uninsured in the country (7%). This rate is even lower than that of the island of Hawaii, with its universal employer mandate system.

Finally, a recent study by Milliman and Robertson, a New York actuary and consulting firm, ranked the health care costs of 400 of the nation's largest metropolitan areas, based on data from 16 of the nation's largest health underwriters. The clear cut conclusion was that Wisconsin communities have among the lowest health care costs in the country, ranging from Green Bay and Appleton (ranking 399 and 398, with cost at 73% of the national average) to Madison (ranked

324 at 82%) and Milwaukee (ranked 227 at 89%). Five of the 10 communities with the lowest costs were in Wisconsin, and Wisconsin overall ranked as the sixth lowest in the nation. Los Angeles, by the way, ranked No. 1, as the most expensive, at 173%, and many Florida and California metropolitan areas were more than 150% of the national average.

Clearly, we do have problems with health care finances in Wisconsin, and these demand our attention, but we also have an excellent and cost-effective health care system, which by many measures, leads the country.

Even though Wisconsin has one of the lowest percentages of uninsured in the country, we should be ashamed that any of our citizens are unable to get the health care they need. As physicians, we must mobilize the political and moral will to ensure that necessary health care is accessible to all.

Unfortunately, public discussion of our health care system is too often limited to political rhetoric, slogans, and superficial or simplistic solutions. Part of the challenge we face is the challenge of exploring and analyzing solutions in an open, honest and thorough manner. This process is demanding, at times frustrating, at times disheartening, but I believe it is essential that we as physicians stick with it and do our level best to help create the health system of the future.

The moral imperative to use our skills to heal the sick should be reason enough for our continued participation and leadership in the health care reform debate. On a more pragmatic note, if we fail to lead, others will certainly do it for us. Politicians of all stripes are eager to solve the problems of our health care system. Medicare and Medicaid were created with the loftiest of goals but have clearly failed to live up to their promises. The political will or ability to rectify the many problems with these programs has been sorely lacking. Government tells us there is no more money for health care while we are forced to spend billions to bail out failed savings and loans. And, in perhaps the ultimate irony, one of our neighboring states has just decided to tax the sick in order to cut health care costs.

The inescapable conclusion is that we best be a part of the solution rather than a part of the problem.

Just as we need your participation in the societal debate on health care, so we also need your participation in this society. The SMS constitution provides that the ultimate decision and policy-making authority of our organization resides not in our leadership but rather in our members and the House of Delegates. Those of us elected as leaders must remember that this House and our individual members remain the cornerstone of our organization. We must strive to be a membership driven society, and ever encourage the participation of our individual members. Conversely, the commitment of your time and energy, and that of your colleagues, is needed now more than ever as we try to shape our future.

The democratic process can be time-consuming, the debate may be intense and moments of frustration inevitable, yet as Winston Churchill said, "Democracy is the worst form of government, except for all the rest."

Though our deliberations may take time and inspire intense debate, I am convinced that this organization and its members are equal to the challenge. Let us not waver in our commitment to democracy in our own ranks.

As this physician's term as president draws to a close, I know that you have chosen wisely in selecting our new president, Dr Bill Listwan.

I certainly would like to thank the staff of SMS for their superb support. I would like to especially thank your chief lobbyist for the last 8 years, and my wife, Terry Hottenroth. Often, her duties in the SMS offices and at the state Capitol precluded her traveling with me on my trips to visit the membership–but her loving support was steadfast, superb and outstanding.

As I turn over the helm of SMS and join the "pumpkin" society of past SMS presidents–I leave with you an excerpt from *The Road Not Taken*, by Robert Frost. (As an undergraduate at Amherst, I experienced this Yankee poet laureate as he lectured on American literature.)

Two roads diverged in a yellow wood,
And sorry I could not travel both
And be one traveler, long I stood
And looked down one as far as I could
To where it bent in the undergrowth...
Two roads diverged in a wood, and I-
I took the one less traveled by,
And that has made all the difference.

150th

Don't be an ash.

If you smoke, you're always left with a bad taste in your mouth.

And that's only the beginning. You'll also endure coughing, shortness of breath and a raw throat. Not to mention yellow teeth and bad breath.

But you already know that.

Keep on smoking and chances are good you'll become part of an exclusive group: the more than 6,000 Wisconsinites who die from smoking-related diseases each year.

Fortunately, the news is not all bad. Because nearly half the adults who have ever smoked have quit. You can too. And the American Lung Association is here to suggest the right way for you.

So don't be an ash. Face the facts. And call the American Lung Association of Wisconsin today. Just dial toll-free 1-800-242-5160.

AMERICAN LUNG ASSOCIATION® *of Wisconsin*
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It's a Matter of Life and Breath®

Address of the president elect

The adventure continues

William J. Listwan, MD, West Bend

THIS EVENING, we have gathered for several important reasons. We are here to honor Kim Hetsko for his year as president. Kim's enthusiasm, energy, and understanding of the complex issues we face today has set a model for me to follow. I became fatigued just watching Kim last year. We are also here to honor some very special people for their accomplishments. Physicians like Jerry Kempthorne and the other award recipients this evening have set an example in giving of themselves for the rest of us to follow.

Another reason to be here this evening is to help me get a good start on my year as president of the State Medical Society. I would like to acknowledge the pleasure and the honor which you, the members of the State Medical Society of Wisconsin, have provided me by allowing me to serve as president of this progressive organization. At the same time, I feel very humble when I look at the task ahead and the many exceedingly capable and hard working people that have preceded me. I will do my best for all of us.

The theme for our meeting this year, the 150th year for the State Medical Society, is "Then, Now, and the Future." In keeping with that theme, I thought it would be quite appropriate to include a little historical information in my presentation.

William J. Listwan, MD, SMS president 1992-1993.

In Milwaukee, in May 1892, 100 years ago, Doctor F.G. Witter opened his presidential address to the State Medical Society of Wisconsin with these words:

> "Gentlemen of the State Medical Society of Wisconsin: I am devoutly grateful for the privilege of extending to you familiar greetings tonight under such favorable circumstances.
>
> I deem it no small privilege to meet you, who have worked side by side in the great field of medicine, and to note that the memory of bygone hours of anxious work and watching has left so many of you still hale and hearty.
>
> With us the old lines of thought are fast being obliterated; the old terms in which we were wont to express the results of our observations are even now rarely heard among us in consultations; new terms and new ideas are taking their places. So it ever has been and ever must be while medicine is a progressive science; until we have solved (if that day shall ever come) all the problems of life and death, of health and disease."

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Later in his address, he added "For, after all, truth ever old is ever new. What is today, is the result of what has been in the past ages; and the same forces are at work evolving the future. And as a consequence, the advances in our knowledge in medical science within the last quarter of the century are without a parallel in any age." No false modesty here.

The theme for my talk tonight deals with "the adventure of medicine." Adventure to me means a challenge, some risk, hard work, fun, and the opportunity for unexpected rewards. In the case of medicine, adventure may also be an opportunity to do good for others. Adventures are fun. When I am driving my car and get lost, or when my day is totally disrupted by unexpected catastrophes, I try to look on that as an opportunity, an adventure. Sometimes we see new places, experience new things, and find unexpected opportunities when everything isn't going exactly according to schedule.

There is perhaps no better time to talk about the adventure of medicine, and the other rewards that go with the practice of medicine, than now. Many of our colleagues seem to be unhappy, discouraged, disappointed, and angry. Not that disappointment and anger are wrong, but for some, these emotions have become the dominant force in their lives.

Recently one of my fellow physicians in West Bend announced that his son was interested in a career in medicine and that he had actively discouraged his son from entering the practice of medicine. I must admit that I felt sad when I head him say this. The emotions he expressed and his reasons for it are not isolated.

In 1987, an AMA survey of 3,183 physicians over the age of 40 who had been in practice for 5 years asked "Given what you know about medicine as a career, it you were in college today, would you go to medical school?" Forty-four percent replied that they would not. In 1990, the Robert Wood Johnson Foundation asked the same question of physicians under the age of 40 who had been out of residency training between 2 and 5 years. Of the 4,574 respondents, 35% responded that they would not attend medical school.

Just so none of you leave here tonight thinking that dissatisfaction with medicine is new in 1992, I would like to share with you information from some of the old transactions of the State Medical Society of Wisconsin. Both the 1891 and 1892 transactions have fairly extensive, and somewhat vitriolic, papers on medical liability.

In the 1891 paper on "Civil Malpractice," Dr Gill, of Madison, writes "Cases of civil malpractice are of frequent occurrence. The frequency with which suits of this character are brought is increasing with such rapidity, that it suggests to the mind of the practitioner of medicine that it is highly important that the profession awaken to the realization of the situation, and make an honest effort to restrict these suits within their narrowest limits." He points out that a medical liability claim "exposes the unfortunate (physician) to a long and serious litigation, severely crippling him financially, or even worse, ruining a reputation to which he has perhaps for years struggled to obtain." With shorter sentences and some grammatical changes, it could have been written today.

And if you think allied health professionals and turf are problems now, you should review some of the history texts and look at the ads, lack of regulation, and sometimes physical violence that occurred in Wisconsin 100 years ago. In late 19th century Wisconsin, as many as one third of practicing physicians were homeopaths, eclectics, hydropaths, or just out and out quacks. Only two thirds of practicing physicians were allopaths or traditional physicians and neither their training nor their practice was regulated in any manner. In 1892, the State Medical Society was struggling in attempts to get the State of Wisconsin legislature to authorize a Medical Examining Board. Today we are struggling to get the Medical Examining Board adequately staffed and funded.

And just to remind you that physicians aren't a new target, I would like to quote from the welcoming speech made by the governor of Wisconsin to the State Medical Society in Madison in May 1891. "I welcome you now, not only to the city of Madison, but to the state of Wisconsin. It is yours to do with as you like and you generally do. There is a quotation from scripture that I have often seen, thought I cannot tell just where it came from, "Physician, heal thyself." Most of you are, no doubt, well heeled by this time, and that (is because) most of us laymen have helped you to become so."

For a few minutes let's think about some of the reasons why physicians in 1992 are becoming so dissatisfied with their chosen profession. In this month's *Annals of Internal Medicine*, Steven Schroeder has a paper titled "The Troubled Profession: Is Medicine's Glass Half Full or Half Empty?" In it he indicates that the reasons behind the dissatisfaction are complex. He includes societal distrust of all national institutions, the change in family dynamics and expectations resulting from two-career families, a decreased willingness among young professionals to forego outside leisure interests, concern about indebtedness resulting from high tuition charges, the threat of malpractice actions, and more assertive consumer expectations that challenge the autonomy of the clinician. He then states that a major, perhaps dominant, reason for physician dissatisfaction results from our nation's inability to come to grips with the rising cost of health care. Out of frustration, society is imposing administrative efforts, which have been quite ineffectual, on physicians resulting in a marked increase in the "hassle factor" which we all see in our daily practices.

Unfortunately, I am not going to tell you how to solve all of the hassle factors in the practice of medicine this evening. Instead, I am going to share with you a way to help our colleagues feel more satisfaction in their profession and the job they are doing in spite of the hassles. Some of our colleagues need a cheerleader to help them find a little sunshine in their days and in their profession. That's our job.

The answer to professional satisfaction for a physician is deciding that the glass is at least half full. I discovered for myself a long time ago that I am personally responsible for my own happiness.

The corollary to that is that if I'm not happy, I can't blame someone else. The other corollary is that I am not responsible for making others either happy or unhappy. But part of the way I am going to find satisfaction and happiness for myself is by helping others. Now helping others isn't really a foreign idea for us, is it?

Let me tell you a story that I think will help illustrate the point I want to make. Many years ago, when I was attending a program for high school religious education teachers at Marquette University, a nun, who happened to be an American Indian, told the following story.

When she was a child growing up on the Indian Reservation out west, finances were very limited in her family. She recalled in particular one Sunday afternoon when their family of eleven was sitting around the kitchen table and her mother and father were arguing violently about the fact that there was only $4 left in the house and no paycheck would be available until next Friday. They were arguing about whose fault it was that there wasn't enough money left to buy food for the rest of the week.

Suddenly her father shouted "Enough!" and thumped his hand on the table. He gave the money to his oldest son and sent all of the children off to the grocery store to buy strawberry ice cream. As much as they could buy. When they returned home, they had a strawberry ice cream party.

To this day, she doesn't remember what they ate or how they survived the rest of the week but everyone is alive and healthy.

The point of her story and the idea I want to underline is that sometimes we take our problems too seriously and sometimes we refuse to see the good things around us, only to focus on those things that we don't like or that irritate us. When we think times are tough we sometimes hoard things out of fear that we may need them in the future and they will be gone. Sometimes we are hoarding material goods in our attics or basements, sometimes we are hoarding our time, sometimes our talents, and sometimes our smiles. Maybe we all need to do a little inventory on our attics, on our time, on our talents and make sure we are not unnecessarily hoarding things that would be better shared with others. Maybe it's better to risk starving and have a few more strawberry ice cream parties. Maybe then there would be more smiles too.

In addition to the need to clean out our attics and to share our things with others, I would like to make one more point. Things will go well for our profession if we remember this very important but simple fact. The patient comes first. Increasingly sophisticated medical technology places reliance on testing rather than talking to the patient and listening to them. All of the regulatory intrusions into our practices, the prospective and retrospective review, statistical analysis of practice patterns, even practice parameters that attempt to make our diagnostic or therapeutic interventions conform, tend to be depersonalizing. The biggest danger facing medicine in the future is that we might allow ourselves to become less personal, less caring, and more entrepreneurial with our patients. The strength of medicine is a caring physician reaching out to a patient and helping them with their physical and emotional problems. It was in the past, it is today, and it will be in the future.

The past 6 months, as I inventoried my attic and looked around for ways that I could help my patients, I have become more and more interested in the issue of domestic violence. Although I initially had the feeling that it was not an issue that I would encounter much in West Bend, even in a primary care practice of Internal Medicine, I have become convinced that I have not been aware of domestic violence problems in the lives of my patients. The statistics speak to a significant problem in our society with violence in general, and in particular to a problem in our society with violence in general, and in particular to a problem with domestic violence.

I have made it a personal goal of mine to become better educated about the issue, to learn how to discuss it with my patients and how to obtain a reliable history from them, and to personally find out what resources are available in my community.

As I travel through Wisconsin, as president of the Medical Society, I will also try to raise the consciousness of other physicians and identify those who are willing, on a personal level, to become more involved in their communities. In know that many county medical societies, like Kenosha, are quite advanced on this issue. I know that the State Medical Society Auxiliary also plans to be involved in the issue of domestic violence. I add my support to all of these efforts that are already occurring.

To those of our colleagues who find themselves unhappy tonight, I say look around you. Open your eyes. There are

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Marquette University Gospel Choir entertains the inaugural gathering.

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both intellectual, emotional and material rewards in our profession. How many others can go home after a hard day's work and always know that they have made at least one person's life better? I can, and so can you. There are other professions that enjoy respect in our communities equal to the respect that physicians enjoy. There are many more professions that don't have the same respect we do. And although we may feel tied down, hassled, and sometimes feel like we don't have much autonomy, I would like to know how many of you have to punch in and out on a time clock? How many physicians have their coffee breaks regulated and timed? How many of you need notes to go back to work after an illness, or have trouble getting a couple extra days off to go skiing when you want to?

The rewards are many, the opportunities unlimited. Although at times we may seem to be the target for everyone who is finding fault with the high cost of medical care and the inability to always find an answer or a cure, I would like to quote Wilt Chamberlain who said, "Nobody ever roots for Goliath." There are days when we are going to have to root for ourselves.

So for those of you who are discouraged, down in the dumps, frustrated with your jobs as physicians, heal thyself. For those of you who have been discouraging your children, or grandchildren, from following you into the practice of medicine, think about the good things you have accomplished and the people you have helped. Think about the good feelings you have had, and I hope you will want your children to have the opportunity to share these feelings with you.

By completing medical school, by your post-graduate training, by preparing for state board and specialty board examinations, you have equipped yourselves with the tools to function as a very significant cog of society. Don't let those tools become rusty with discontent or discouragement. Polish them and sharpen them so that you can apply them skillfully in the ultimate adventure we all experience. The adventure of being a proficient, ethical, caring physician.[15th]

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AMERICAN MEDICAL WRITERS ASSOCIATION

Executive vice president's speech

The search for our future

Thomas L. Adams, CAE

LADIES AND GENTLEMEN, a typical moment in Dr John Doe's life:

"Mrs Bratwurst, I'm glad you stopped in to see me. Based on the test results, your personal and family history, and my examination of you, I am confident that a hip replacement will be the best treatment for you.

"Will your insurance cover it? I'm not certain, but I can make a call and ask. What insurance company are you with? You're not sure. OK, what's the symbol? A forest animal? A mountain? A piece of armor? I see, it's the one with the TV commercial where the agent sprinkles sweet dream dust over your family as they sleep and then stands guard all night on your front porch. That would be the Down Home Insurance Company, International. Let me see if I have a number for them.

"Here it is.

"Good afternoon, this is doctor– It's a recording: all the customer service agents are currently busy.

"What's that? The on hold music? I think it's Zanfir doing the best of Ted Nugent on his pipes.

"Yes, nurse? The next patients are waiting? Please tell them I'm sorry and I'll be with them as soon as I can.

"Hello? Yes, this is Dr Doe in Sheboygan, Wisconsin. I need to check on the coverage of a certain procedure for one of my patients. How's that? I need to call your managed care firm? What is the number there?

"I'm on hold while they look up the number. Hey, now it's an elevator version of Beethoven's 9th.

"Yes, yes, I'm still here. One, eight hundred, stone wall. Thank you.

"Hello? Yes, this is Dr Doe in Sheboygan, Wisconsin. I need to check on the coverage of a certain procedure for one of my patients covered by Down Home Insurance, International. How's that? I need to talk to the case manager in the billing arm of the midwestern division of the department of coverage for the western half of the northern hemisphere? Well, can you connect me?

"They're where? The London office? (Sigh) Give me the number, please."

Thomas L. Adams, CAE, SMS executive vice president

Ladies and gentlemen, nobody likes the current system of health care delivery and financing. Patients hate it, doctors hate it, insurance companies hate it, employers hate it, and politicians are learning to hate it. It wastes time. It wastes millions of precious health care

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dollars. It violates the physician-patient relationship. It threatens the financial strength of too many small businesses. It leaves too many people without coverage. It threatens the economic and physical health of too many families. And it encourages too many people to play shell games, shifting costs and responsibilities from one group to the next.

Physicians have been convenient scapegoats in this game of placing blame. It seems that sooner or later every player gets around to pointing at the big bad doctors. I've heard your complaints. I know of your compassion. I know of your charity. I know of your involvement in your communities. I know of your frustration with the bureaucracy that carves an ever greater chunk out of the time you want to devote to direct patient care. I know of your dislike of those who would paint you as adversaries of your patients, who try to build a wall of mistrust between you and the people you are trying to help.

Perhaps the time has come to quit complaining. Perhaps the time has come to act boldly.

I believe the time has come to wipe the slate clean and begin an examination of the system's symptoms, the weaknesses that are causing those symptoms, and the wide range of possible cures. We must approach health care reform with the same scientific impartiality and methodology we would use in combating a new disease. We may have to challenge more than a few accepted notions and cherished expectations. We may have to adapt to a new way of practicing medicine. We won't know until we begin our study, but we must commence the process ready to accept what we find and to do what is necessary.

In survey after survey, in meeting after meeting, in conversation after conversation, the members of the State Medical Society of Wisconsin have said they want their professional association to take the lead and direct change, not follow or react to it. That attitude has so long been prevalent in Wisconsin that it has come to stand as a definition of Wisconsin's character. As even the briefest review this society's 150-year history will show, Wisconsin's physicians are part of that tradition. When you consider that the UCR system was, for the most part, an invention of this society during the 1960s, you begin to realize the magnitude of the leadership wisconsin's physicians have provided.

The SMS was a leader in creating and promoting the 12-point plan, Operation Reform, seven points of which were recently passed with the governor's Small Businesses Health Initiative by both houses. It was a good first step, but it was only a first step. A small step. The bill, AB 655, does have weaknesses. Most notably, it fails to address the crucial issues of tort reform and the continued inadequate funding of medical assistance. We must continue to pursue our objectives in these areas, but we must also go farther.

I believe we must go much farther. We may not be able to create a system that will enhance the professional lives of every physician. And we may have to adapt to a system in which some medical practices are much different from what they are today. But we have been told that physicians hold the key to successful health care reform, and to some extent that is true. I am confident that we are able to accept that challenge.

Part of that certainty is born of forces outside our own ranks. As our friend Senator Brian Rude recently said: "the logical next step for the Legislature is to broaden the look at physicians." So part of our motivation for participating in the evolution of the profession is to keep others from dictating to us the terms of our existence. But that is not our greatest motive.

Our desire for change is rooted firmly in our recognition of our need. Physicians are the one group of players that come into contact with all of the players in the health care arena–patients and politicians, industry and insurance–so physicians see better than most the arena's state of disrepair. Physicians are also the only players in the game who are directly, immediately and daily involved in the effort to heal the sick and injured, and if the system stands in the way of those efforts, physicians will be quick to demand modifications to that system–or a new system entirely. As expected, you have done precisely that.

I believe that the leadership of this society has the foresight and knowledge to take the lead role in designing a unique Wisconsin response to reform of the health care delivery system. I propose that this society form a task force of some of its best minds to study the possibilities, exercise their imaginations, and create the new Wisconsin idea. I propose that this society make available all resources necessary for this task force to carry out its historic charge.

We have been victimized by finger-pointing for too long, and it is time to face our challengers. It is time to create a health care systems reform plan that can not only spread the burdens and rewards of reform fairly among the players, but can win bipartisan support and actually pass into law.

I propose that the chair of the SMS Board of Directors appoint this task force, and that the task force begin its work, as soon as possible. Finally, I propose that this task force prepare its findings for a report to this house at its meeting next April, or sooner if possible.

Medicine has long been accused of only being against things; now is the time, now is our opportunity, to say what medicine is for.

The costs of health care have been a constant in the social debates up to this point, and they must continue to be a large part of our discussions. And as we begin our exploration of reform possibilities, we may want to examine–as others have and will–the health care systems of other nations. As with every other facet of the reform discussion, we must dispense with emotional rhetoric and consider cold, hard facts. And in this discussion, I think it warrants noting that Wisconsin ranks 47th in the nation for per family health care costs. It also merits mentioning that the per capita spending increases for health care in Britain, France and Canada have been higher than that of the United States. Between 1970 and 1989, health care spending in the United States increased by eight-fold; but in Canada it rose nine-fold, in France 12-fold, and in

Britain 13-fold. Japan's increases were similar to our own. Only Germany had a significantly lower increase in per capita health care costs. This is not to say that Germany holds some panacea for us, but it may be one of the models we wish to consider.

Germany guarantees access to health care for all of its citizens, but it does so through a private-sector insurance system. Germany is second only to the United States in the availability of advanced equipment such as CAT scans and magnetic resonance imaging, and they render care without the long waiting lists so common in Canada. We should research and consider a modified German plan, in which a public utility-style citizen board sets the rates for the basic insurance covering everyone but allows market forces to determine the rates for supplemental coverage. This is not to say that the German system is without its problems–but it may prove a workable model when we explore reforms for our own system.

Two other interesting proposals for reform surfaced last week, one from the American Academy of Family Physicians and another from the American Society for Internal Medicine.

The academy's model would cover everyone through either their employers or a public plan, and require every patient to select a primary care physician. The academy also called for the adoption of expenditure caps and resource-based fee schedules.

The Society of Internal Medicine's plan called for acceptance of a uniform RBRVS with allowances for different conversion factors to be used by government, private payers and physicians. The society also advocates creation of a national health care objectives board that would develop expenditure goals.

While these may or may not hold some of the answers we seek, they are examples of the boldness of thought that will be required. We will need to free our thoughts of constraint and unleash our greatest, our most radical, creative abilities.

We will address your frustration with the bureaucratic swamp of ever-changing regulations and ever-growing paperwork, as well as the walls that are being erected between you and your patients. But we must also address a number of issues that are extremely important to the other health care players, including overall costs, appropriate use of procedures and technology and physician fees. The time has also come for us to squarely face the issues that arise from what is politely referred to as the "end of life crisis." Disinterest, complacency and hesitation are inappropriate responses, for if we fail to address these issues, others will not.

Pauline Jackson, MD, escorted by Kermit Newcomer, MD, receives a standing ovation as she is installed as the first woman president elect of the SMS.

We have heard a great deal, in these past few months, about what is wrong with our health care system. But before we go too far in our self-condemnation, I think we will do well to step back and consider what good we have accomplished despite our flaws. Medicine, to put it bluntly, is at its zenith.

At no point in the history of humankind has health care been more available to more people. According to the Health Insurance Association, the number of Americans without any health coverage has remained constant at around 31 million, while the number of people with coverage has increased more rapidly than the growth of our overall population–and now reached nearly 217 million.

At no point in the history of medicine has our ability been greater to relieve suffering, to heal injuries, to cure diseases and to prevent health problems. We now enjoy the most advance technology, the most sophisticated procedures, the most powerful medications, and the most educated and able physicians.

In the midst of that brilliance, medicine must acknowledge its failings and accept its responsibility to change. In the coming months, your society will need your help in fulfilling that charge. Your society will need your support in opening the full realm of possibilities, your help in bringing together the proposed task force, and your energy and intelligence in exploring the health care of the future.

The uninhibited search for our future is a mandate laid down for this society by this House of Delegates when it adopted its new strategic plan last year. The question will be whether we have the courage to match our convictions. For the sake of the profession, for the sake of the public health, I trust the answer is affirmative.[15]

The fallacy of health care

Howard Correll, MD, Arena

Dr Howard Correll delivered the following address to his fellow SMS past presidents at the 1992 SMS annual meeting.

During more than 60 years in medicine, I witnessed its emergence from its near medieval state. I am aware of misconceptions in the unity in the life of man, the planet, and other organisms; second, misunderstanding as to what medical care, health care and national health insurance are; and third, misunderstanding of the order in which medical care and health care must be used. Failure to appreciate these inconsistencies, are symptomatic of our inability to recognize conduct consistent only with a prematurely barren earth.

Through time, until perhaps 2,000 to 3,000 years ago, man had the concept of mother Earth, as integral in all his religious beliefs, worshiping it and respecting its authority over his actions. Then, in some religions, the concept emerged of man's ownership of the Earth. This drastically altered the relationship of the Earth's only inhabitant who had developed the logic of thought, thus learning to apparently control its destiny. It also altered the evolutionary process from change for its sake, to change for the sake of man. What he owned was his, to be used for his personal welfare. In fact, he had the right to do so, and if he wished, to destroy, rather than use the discrimination necessary for concern about the life of the planet on which his future welfare depended. Perhaps to justify this, the concept of rights developed. But for this to occur, exclusions were needed, since one persons right was another's loss.

As Darwin observed, for preservation of the species, self-protective mechanisms developed, one form of which we term greed, especially when used for individual rather than species protection. It is this attribute of man that concerns conservationists, as well as all seeking justice in our imperfect society. It is this primitive emotion, used judiciously or injudiciously, deservedly or selfishly, that separates man from other mammals. It is the propriety of its use, variously expressed as ownership, inalienable rights, property, and health care, that has recently concerned men like John Muir, Aldo Leopold and Van Potter, all residents at one time of southern Wisconsin, as well as, in more ancient times, Jesus Christ, in his parable about the camel, the needle's eye gate into Jerusalem and the rich man entering Heaven, assuming that to be the perfect life. All these men, as well as Siddartha the Buddhist, and many others of the ancient philosophers, recognized the unity of all forms of life and the earth, as well as their interdependence. Only some modern men deny it. This is what is mentioned as the first misconception under which we labor.

The term health care is the second misconception. No one, to my knowledge, differentiates between individual and public health care, though, this lack in discriminate thinking is responsible for the public misunderstanding. Physicians however, have recognized this difference, since knowledge of the relation of microorganisms to infection and certain chemicals as poisons to man. That is why physician specialization in public health developed. While all physicians maintained an interest in these problems, they left detailed management to those specializing in it.

The public health physicians meanwhile, did not generally interfere with their private practice colleagues until government intervention in its payment mechanisms, about 50 years ago, caused politicians to mandate their surveillance. These were rapidly extended to regulations effecting drugs, research, diagnostic devices and treatment programs. This growing compartmentation of medicine, made a previously, more or less cohesive profession, a divided, often antagonistic one. How did this come about?

In my 8 years in premedical and medical school, and 6 years in training hospitals associated with midwest medical schools, the practice of medicine was slowly evolving. It was then a profession devoted primarily to recognition of abnormalities, a few diseases prevented by immunization or vaccination, a few accidents and diseases correctable by surgery, and for the delivery of babies. There were no specific treatments for most medical conditions. Diagnostic equipment, drugs and treatment regimes were simple. All were directed toward comfort, rather than cure. Because of this relative absence of curative intervention, medical malpractice could seldom occur, since what no one could cure, no one could be held responsible for failing to cure. The same was true for rights. Liability insurance was, therefore, cheap, as was the total cost of medical care. Its value was so little prized that interns were on duty 24 hour days, 7 day weeks, without pay, residents for no or very tiny stipends. Yet, we felt medicine had come along way from the 16th century physician who advertised, "When peoples ill, they comes to I, I physics, bleeds and sweats 'em. Sometimes they lives, sometimes they dies. What's that to I? I lets 'em." While honesty in advertising has regressed since then, medicine has progressed and public expectations for cure have exploded, since human nature always expects more when it gets more.

In 1938, when I was a fourth-year resident at Milwaukee County General Hospital, the pleurisy accompanying pneumonia was treated with mustard plasters, the skin irritation presumably distracting the patients attention from the pain induced by breathing. In summer, children were kept indoors to avoid poliomyelitis with its frequent paralyses. In fall, hospital wards were emptied to receive the lobar pneumonia epidemic where one

third died, one third recovered and one third developed lung abscesses or empyema, those surviving requiring up to a years hospitalization, with frequent surgical drainages. Tuberculosis was always present. As I recall, between 5% and 8% of my intern group developed active disease in that year, all requiring at least 2 years of bed rest, if they lived. While I became tuberculin positive on the active tuberculosis ward, I did not then or later become clinically ill.

In 1938, with the advent of Prontosil, the first orally administered sulfa drug, all this dramatically changed. Ninety-eight percent of the lobar pneumonia patients became afebrile in 2 days and were cured in 7 days. Empyema and lung abscess disappeared. Even subacute bacterial endocarditis was occasionally cured. With the advent of penicillin, a few years later, it was usually cured. Medical care had evolved into a profession, not only capable of curing disease, but of attracting the attention of politicians, whose business was protecting the public. Medicine entered the political domain. Its care was now valuable enough to be a right, though strangely good housing, good education, good jobs and two parent families were not.

'Health care, delivered by physicians, is not designed to ensure public health.'

This raised questions. Was medical care the totality of health care? Where did the above public health problems fit? Does the result of calling medical care, health care, confuse the public by obscuring the difference? Is the concern for the 20 to 30 million Americans without health care insurance, really medical care insurance, valid?

For understanding, we must define medical and health care. Medical care is the prevention or treatment of disease or accident in the individual. It is a private transaction between parties, as plaintiff attorneys always attest. What is not part of the definition, is the occasional overlap, where enhancement of the individual good is extended to society. This is why medical care is a small part of public health care. But this difference is also why the Public Health Service, and later the World Health Organization had to be developed. They are entities responsible for different aspects of personal and public health. The World Health Organization defines its functions as the development and maintenance of the physical, mental and emotional health of the world public. It encompasses more and different things than our legislators empower our public health service to perform

We must inquire as to the order in which medical and health care must be used, to be effective. Is the reason most of those who do not have medical insurance, not solely because they cannot afford it, but also because they are insufficiently educated, or live in situations making it impossible for them to use it effectively? These factors include good education, jobs and housing, lack of two

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The 1992 SMS 50 Year Club. See page 448 for a list of honored members.

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parent families and of personal hygiene.

Have not we, the public, failed in not providing the education necessary for good jobs and homes, necessary for them to use the sophisticated care available? When we allow people to live in squalor, lack personal hygiene, deprived of personal pride in self and community, and otherwise destroy their moral values, are not we degrading both ourselves and them?

These are the real public health problems which must precede good medical care. People like Jack Kemp and his advisers in public housing, and Polly Williams, with parent selection of education, are enunciating these real public health concerns which, if treated first, will decrease the need for the health care claimed to be so necessary.

Medical care, delivered by physicians, is not designed to ensure public health. Society and government are the only instruments that can do this and both have failed, as has our social protector, the press. Society must reinstitute the two parent family for stability, the moral indoctrination of the churches, both of which build respect for self and community, the good education necessary for the work ethic to fill the sophisticated jobs, and world wide knowledge that population must remain within bounds the planet can support.

Respect for the unity of man and the Earth, attainment of real public health, and then use of medicine, are the means to a better life on a planet, then compatible with long sustained life.[150th]

Awards presented at the SMS annual meeting

Each year, during its annual meeting, the SMS recognizes leaders in health care, both physicians and nonphysicians, who have made significant contributions to the health and well-being of Wisconsin physicians. The following awards were presented during the 1992 annual meeting in Milwaukee.

Fifty Year Club

Each year, the SMS honors its members who have served the profession and patients for more than 50 years. This year, 63 physicians were inducted into the 50 Year Club during the Board of Directors luncheon at the annual meeting. Graduates of the class of 1942 include:

George R. Barry, MD, Monroe
George A. Behnke, MD, Appleton
Frank Belfus, MD, Mequon
Maxine Bennett, MD, Madison
George A. Berglund, MD, Milwaukee
Henry F. Bischof, MD, Lake Geneva
Marvin D. Blackburn, Jr, MD, Edgewood, Texas
Joseph N. Bonner, MD, North Fort Myers, Fla.
Sidney M. Boxer, MD, Sun City West, Ariz.
William O. Brand, MD, Milwaukee
John L. Burns, Jr, MD, Marshfield
Robert E. Callan, MD, Wauwatosa
Thomas L. Calvy, MD, Wauwatosa
Daniel M. Clark II, MD, Rockton, Ill.
Richard P. Cramer, MD, West Allis
G. Stanley Custer, MD, Marshfield
Bertram H. Dessel, MD, Wauwatosa
Donald G. Dieter, MD, Madison
Anton S. Dorn, MD, Brown Deer
Jack A. End, MD, Milwaukee
Frank P. Falsetti, MD, Sanibel, Fla.
Leonard Gorenstein, MD, Milwaukee
Arthur B. Grant, MD, Racine
George H. Handy, MD, Sun City, Ariz.
George C. Hank, MD, Friendship
Oliver M. Hitch, MD, Green Bay
Roy Hong, MD, Wild Rose
Wallace G. Irwin, MD, Naples, Fla.
Dominic A. Kuljis, MD, Two Rivers
B. Jack Longley, MD, Madison
William V. Luetke, MD, Naples, Fla.
John D. Lynch, MD, Estero, Fla.
Robert J. Mathwig, MD, Stanley
J.R. McNamee, MD, Boscobel
Gerald B. Merline, MD, De Pere
Francis J. Millen, MD, Milwaukee
Howard V. Morter, MD, Blairsville, Ga.
Kenneth J. Moss, MD, Marinette
Barbara Mounts, MD, Neenah
Benjamin G. Narodick, MD, Mequon
R.M. Nesemann, MD, Kewaunee
Louis G. Nezworski, MD, Eau Claire
Mark T. O'Meara, MD, La Crosse
Andrew J. Owens, MD, Elm Grove
Louis J. Paquette, MD, Milwaukee
Russell S. Pelton, MD, Ripon
James C. Pinney, MD, Kaukauna
William H. Pollard, Jr, MD, Beloit
Margaret Prouty, MD, Madison
Raymond W. Quandt, MD, Jefferson
Elmer P. Rohde, MD, Galesville
Earle J. Rotter, MD, Boca Raton, Fla.
Shimpei Sakaguchi, MD, Arvada, Colo.
Jack D. Schroeder, MD, Janesville
Robert L. Schwab, MD, Hutchinson, Kansas
Walter F. Smejkal, MD, Manitowac
J. Kent Tweeten, MD, Madison
Allen Twyman, MD, Beloit
Eugene J. Usow, MD, Laguna Hills, Calif.
Marvin Wells, MD, Albuquerque, N.M
Richard C. Wixson, MD, Sister Bay
Charles W. Young, MD, Platteville

Houghton Award

The Houghton Award of the SMS Charitable, Educational and Scientific Foundation is presented each year to senior medical students who demonstrate scholastic excellence, extracurricular involvement and interest in medical organization. In presentations at the 1992 annual meeting, recipients were each awarded a check for $500 and an engraved plaque.

Recipients of the 1992 Houghton Award

were Michelle M. Agnew, of Brookfield, a senior at the Medical College of Wisconsin (MCW) and David C. Dries, of Madison, a senior at the University of Wisconsin Medical School.

Agnew was recommended for the award by Herbert W. Swick, MD, MCW senior associate dean for academic affairs, who said, "Throughout both her basic science and clinical years, she has maintained excellent academic progress, and her fine clinical skills are attested by numerous evaluations of honors in her clinical clerkships. Faculty in her clerkships have commented frequently upon her responsibility to the professions, to her patients and to her colleagues."

Agnew serves as student representative on the MCW admissions committee and MCW Faculty Assembly. She is a student volunteer for the MCW Cares AIDS Education Program and served as chair of the 1990 MCW Blood Drive. She is a member of the American Medical Association, the American Medical Student Association and the Christian Medical and Dental Society. Her community activities include volunteering as assistant coach to the Special Olympics swim team.

Carl J. Getto, MD, acting dean of the University of Wisconsin Medical School nominated Dries for the award, citing the medical student's excellent academic ranking and involvement in professional medical organizations.

Dries has served as a medical student representative on the Board of Directors for the State Medical Society of Wisconsin and as president of the Medical Student Section of the AMA at UW-Madison. He is a former chair of the Midwestern Region of the AMA Medical Student Section. A graduate of Memorial HIgh School in Madison, Dries earned a bachelors degree with honors in molecular biology from the University of Wisconsin-Madison. He plans a career in ophthalmology.

Kenneth T. Bastin, MD (l) receives the 1992 WMJ Resident Medical Writing Contest award from Richard D. Sautter, MD, medical editor (r).

Beaumont Lecture Award

Established by the SMS in 1957, the William Beaumont Lecture commemorates one of Wisconsin's pioneer surgeons. Sponsored by the SMS Charitable, Educational and Scientific Foundation, it is designed to present to members of the Society, distinguished medical scientists whose research and clinical experience may enrich the knowledge and skills of Wisconsin practitioners. The lecture is given each year during the surgery meeting of the SMS annual meeting to honor William Beaumont, an army surgeon who in the 1830s performed a series of experiments on digestion that laid the foundation for understanding the digestive phenomenon.

This year's award was presented to J. David Richardson, MD, of Louisville, Ky, who spoke on "Occult Gastrointestinal Bleeding."

Elvehjem Memorial Lecture

The Elvehjem Memorial Lecture was established in 1962 to honor the memory of Conrad A. Elvehjem, PhD, the 13th president of the University of Wisconsin and an internationally recognized authority on biochemistry. Sponsored by the SMS Charitable, Scientific and Educational Foundation, the award is designed to perpetuate Dr Elvehjem's contributions to the betterment of the health of the people of Wisconsin and the continuing medical education of physicians.

The 1992 award was presented to Mahendr S. Kochar, MD, of Milwaukee, who gave a lecture titled, "Hypertension in Diabetics: Diuretic Problems."

Meritorious Service Awards

Twelve individuals were honored at the 1992 annual meeting for exceptional leadership and dedication to the State Medical Society of Wisconsin and the health of Wisconsin citizens. They are:

- Jan E. Erlandson, MD, of Monroe, for his two years of service as a member of the Board of the State Medical Society of Wisconsin.
- Marwood E. Wegner, MD, of St. Croix Falls, for his nine years of service as a

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member of the Board of the State Medical Society of Wisconsin.

- Joseph J. Mazza, MD, of Marshfield, for his 11 years of service to the SMS Commission on Continuing Medical Education.
- Robert T. Cooney, MD, of Portage, for his 10 years of service to the SMS Commission on Mediation and Peer Review.
- Irwin J. Bruhn, MD, of Walworth, for his nine years of service to the SMS Commission on Public Information.
- Kay E. Jewell, MD, of Madison, for her 10 years of service as a committee member and six years as chair of the Committee on Aging, Extended Care Facilities, and Home Health Care.
- Joanne A. Selkurt, MD, of Whitehall, for her 11 years of service as a member and for her service as vice chair of the Committee on Maternal and Child Health.
- John W. Faber, MD, of Neenah, for his 10 years of service as a member of the SMS Committee on Medicine and Ethics.
- G. Daniel Miller, MD, of Dousman, for his 10 years of service as a member of the SMS Committee on Medicine and Ethics.
- Rudolf W. Link, MD, of Lodi, for his 10 years of service as a committee member and two years as chair of the Committee on Mental Health.
- Peter L. Eichman, MD, of Madison, for his five years as a director of the Board of the State Medical Society of Wisconsin and 10 years of service as a member of the Committee on Mental Health.
- LaVerne Bartel, of Madison, for her 22 years of service to the SMS and its Auxiliary.

Health Leadership Award

The Board of Directors created the Health Leadership Award to honor a person or persons in government service who have made significant contributions to the development of health care policies which benefit the state of Wisconsin. The 1992 award recipients are: Senator Thomas Barrett (D-Milwaukee) and Senator Joanne Huelsman (R-Waukesha) together with Representative Mary Panzer (R-West Bend) and Representative Jeannette Bell (D-West Allis).

Senator Barrett has a long history of leadership on health care issues and has fought to protect quality and improve access to health care for all Wisconsin citizens. He has played a key role in fashioning state policies which address the medical needs of under-served areas, including Milwaukee's central city. He has also been a leader on important bioethical issues, including laws such as the living will law and the durable power of attorney for health care. These laws help to protect patients' rights to choose the kind of health care they want, especially in cases where there may be ethical or philosophical differences on the proper role of modern medical technology.

Barrett, who represents the 5th Senate District, was elected to the Senate in a 1989 special election after serving in the state Assembly where he chaired the Health Committee. He currently serves as chair of the Senate Committee on Transportation and Utilities and is a member of the Select Committee on Health Care Access and Affordability; the Committee on Agriculture, Corrections, Health and Human Services and the Committee on Education, Economic Development, Financial Institutions and Fiscal Policies. He is co-chair of the Joint Survey Committee on Tax Exemptions.

Senator Huelsman has been a leader in the fight for medical liability reform. She has sought to hold down health care costs and improve access to care by promoting legislation to improve the medical liability climate in Wisconsin, as well as other steps. She has been a leader on health insurance reform legislation.

Huelsman, who represents the 11th Senate District, is serving her first session as a senator after completing four sessions in the state Assembly. She serves on the following Senate committees: Select Committee on Health Care Access and Affordability; Education, Economic Development and Financial Institutions and Fiscal Policies; Housing, Government Operations and Cultural Affairs; and Mining.

Representative Bell has played a key role on many important health care issues, particularly those addressing the health needs of women and children. She has been a leader in efforts to improve access to prenatal care, especially for low-income women, and has championed efforts to improve the Healthy Start Program and other maternal and child health programs. She chaired the Legislative Council's Special Committee on Prenatal Care over the last two years and has contributed much to health care policy development in the state.

Bell chairs the Assembly Committee on Ways and Means and is a member of the Committee on Children and Human Services; the Judiciary Committee; and the Committee on Small Business and Education. She also served as a member of the Joint Finance Committee from 1987 through 1990. She was first elected to the Assembly in 1982.

Representative Panzer has been a tireless leader in efforts to make affordable, high-quality health care accessible to all Wisconsin citizens. She has played a key role on a wide range of important health care issues: health insurance reform, reforming our medical liability laws, improving access to care for Medicaid patients, providing preventive health services, improving treatment for mental illness, and many others. Her knowledge and commitment on so many diverse health issues has been a real asset for health care policy development in the state.

Panzer is the ranking minority member of the Joint Committee on Finance and serves on the Special Committee on Reapportionment. She was first elected in 1980.

Presidential Citation

Since 1959, the president of the SMS, with the approval of the Board of Directors, has had the privilege of presenting a presidential citation to a physician or non-physician who has made an outstanding contribution to medicine or public health.

In 1992 Thomas L. Schlenker, MD, special deputy commissioner of health for the city of Milwaukee, was honored for his outstanding contributions to better the health of the people of Wisconsin, especially the children of the state through the development of the Happy Birthday Two-Year-Old Project, aimed at reducing serious under-immunization levels among

Milwaukee's 10,000 2-year-old children.

The Milwaukee physician was instrumental in the development of a computer database tracking immunizations for Milwaukee children to make sure every child in the city is immunized, reducing the risk of disease outbreaks and epidemics.

Dr Schlenker has also demonstrated compassion through his involvement in public health issues at home and abroad. He was a member of a special investigative team sent to El Salvador in 1989 to investigate human rights abuses.

The Director's Award

The Director's Award is the highest award bestowed by the SMS and is granted only on occasion to those who have served with outstanding distinction the science of medicine, physicians and the citizens of the state of Wisconsin. In the 63 years since it was established, the Director's Award has been presented 53 times.

Gerald C. Kempthorne, MD, of Spring Green, was the recipient of the 1992 Director's Award presented in a special Milwaukee ceremony.

A respected and concerned leader, Dr Kempthorne has played a strong role in organized medicine. He was elected to the office of president elect of the State Medical Society of Wisconsin in 1981 and served as president of the SMS in 1982. Dr Kempthorne's list of accomplishments is vast. He is the founding chair and organizer of the Medical Directors' Subdivision of the HMO Association of Wisconsin. He was named Physician of the Year by the Wisconsin Association of Nursing Homes in 1981. He currently serves as chair of the Medicaid Medical Audit Committee and as president of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

Dr Kempthorne is best known, however, for his leadership role in creation in 1977 of the Impaired Physician Program, now named the Statewide Physician Health Program. He was appointed and remains chair of its Managing Committee, a role he has fulfilled with a great deal of caring and compassion. Kempthorne has stressed the importance of aiding-not abandoning-physicians in need.

Dr Kempthorne's practice as a family

Continued on next page

The 1992 SMS Board of Directors. *See pages 359-369 for more information.*

physician in Spring Green has spanned three decades. He is board certified as a Diplomate of the American Board of Family Practice and is a Diplomate of the National Board of Medical Examiners.

A native of Platteville, Dr Kempthorne graduated from the University of Maryland School of Medicine and College of Physicians and Surgeons in 1961, then went on to intern at Cook County Hospital in Chicago, Ill. He is a veteran of the US Navy and the Korean Conflict.

Dr Kempthorne has also reached out into his community, supporting K-12 education as a school board member and past president of the River Valley School District and nurturing the arts and theatre. He has been a board member of the American Players Theatre in Spring Green since 1980. This dedication earned him the Governor of Wisconsin's Award for personal service to the arts in 1982.

Distinguished Service Award

Established in 1974, the Distinguished Service Award is presented each year to a Wisconsin physician who has made outstanding contributions in the field of medical education.

This year's recipient, Richard Shropshire, MD, of Monona, was recognized for his outstanding contributions to medicine through his work to establish the Summer Externship Program, a program which has helped to ease the shortage of primary care physicians, especially family physicians, in the state. Since its inception, the program has placed over 1,000 medical students in the offices of practicing physicians for two- or three-month externships. All support for this program has been from private sources with no state of Wisconsin or federal tax dollars used for support.

The SMS award also honors Dr Shropshire for his support of the Wisconsin Research Network (WReN) which has become known as one of the best primary care practice-based resource networks in the United States.

Retired from practice as a family physician, Dr Shropshire graduated from the University of Iowa College of Medicine in 1953. He completed an internship and residency at D.C. General Hospital in Washington, DC. He is a past president of the Wisconsin Academy of Family Physicians and former director of the Family Practice Program at the University of Wisconsin's Department of Family Medicine and Practice.

Medical Issues Reporting Award

The Medical Issues Reporting Award, established in 1990, is presented to the Wisconsin journalist who best reports on medical issues during the preceding year. This year's recipient was William Wineke, health reporter for the *Wisconsin State Journal.*

A graduate of the University of Wisconsin-Madison and Chicago Theological Seminary, Wineke covers health and religion for Madison's morning newspaper. For 15 years, he has also been chaplin of the Wisconsin Rescue Mission, a Madison charity that provides food, clothing and religious services to the city's poor.

As a health reporter, Wineke has covered the development of HMOs, the consolidation of hospitals and the rising cost of health care, malpractice insurance, medical technology and the Medicaid program.

Wisconsin Medical Journal Writing Contest and the Graduate Student Nursing Writing Contest

For the fifth consecutive year, the *Wisconsin Medical Journal* sponsored a writing contest for medical students, residents and graduate nursing students. The goal of the contest is to encourage and reward good science writing and to cultivate interest in the Society among students and residents.

The winners of the 1992 Medical Writing Contest were each presented with a plaque and a check for $500–funded by the Marshfield Medical Research Foundation, the SMS Charitable, Scientific and Educational Foundation and the Gundersen-Lutheran Hospital Foundation. The 1992 winners are: Kenneth T. Bastin, MD, of Madison; Kurt Hansen, a fourth year medical student at the University of Wisconsin School of Medicine; and Janet M. Zimmerman, RN, of Madison.

The annual writing contest features competition in three categories: medical students enrolled in either of Wisconsin's two medical schools; residents actively training in Wisconsin; and graduate nursing students studying in Wisconsin. The subject matter of the contest entries must fall within the parameters of scientific medicine: clinical, case report, research and review.

Physician-Citizen of the Year Award

The SMS Commission on Public Information, which carries the charge of soliciting nominations and selecting winners for the medical society's annual Physician Citizen of the Year award, has named a winner from each of the eight SMS board districts. Physician-Citizens of the Year are nominated by members of their own communities in recognition of their exemplary commitments to community service. The 1992 winners are:

District 1-Marvin G. Parker, MD, of Racine, for his work to increase access to health care for the uninsured;

District 2-Clemens S. Schmidt, MD, of Boscobel, for his extensive volunteer efforts to better the mental health of thousands in southwest Wisconsin;

District 3-Michael S. Garrity, MD, of Prairie du Chien, for his efforts as a longtime team physician and multiple other volunteer activities;

District 4-Robert W. Page, MD, of Marshfield, for his work in support of the disabled, especially those with multiple sclerosis;

District 5-Alvin C. Theiler, MD, of Keil, for his efforts to construct a hospital and his involvement in Scouts and other community projects;

District 6-Robert E. Johnston, MD, of Green Bay, for his dedicated involvement in the New Community Clinic of Green Bay (formerly the Free Clinic);

District 7-Daniel T. Kincaid, MD, of Eau Claire, for his commitment to youth athletics and education; and

District 8-Edward V. Vandenberg, MD, of Ashland, for his many efforts to meet the medical needs of northern Wisconsin's poor and uninsured residents.

CESF facts

THE SMS CHARITABLE, Educational and Scientific Foundation is a non-profit, non-stock Wisconsin corporation, chartered in June 1955. As stated in the bylaws, the foundation's purpose is to "engage in, assist, and contribute to the support of charitable, educational, and scientific activities and projects and to contribute to the support of, and to create and maintain, charitable, educational, and scientific institutions, organizations, and funds of any and every kind."

Management

The foundation's governing power is vested in a board of trustees composed of directors and officers of the SMS, other medical and non-medical members elected by the board of directors and one representative elected by each component medical society. Non-medical members may be elected from time to time by the SMS Board of Directors, but the number of such trustees shall not at any time be less than five or more than ten.

The board of directors of the corporate trustees consists of 18 members including the president, vice president and treasurer of CESF, and in addition, 12 members, seven of whom may be non-medical trustees, each elected for staggered 3-year terms.

Registration

The foundation is registered with the secretary of state as a charitable organization for purposes of contributions and fund-raising under Wis Stat §440.41(2).

Legal

The foundation retains Robert B.L. Murphy of the firm Murphy & Desmond, SC, 2 E Mifflin St, Madison, WI 53703; 608-257-7181, for advice on legal and tax matters. Julie A. Hein serves as the managing director who works directly with the executive vice president and deputy secretary of SMS and is responsible for all duties of the foundation.

Tax information

Contributions to the CES Foundation are tax deductible under both state and federal tax laws. The foundation is a 501(c)(3) non-profit corporation. As in all matters relating to your financial affairs, the valuation, form and tax aspects of gifts, to the foundation should be discussed with your attorney, accountant or other advisor.

Officers

President: Gerald C. Kempthorne, MD, of Spring Green
Vice president: Stephen B. Webster, MD, of La Crosse
Treasurer: Richard W. Edwards, MD, of Richland Center
Secretary: Thomas L. Adams,* of Madison
Finance Committee chair: Richard W. Edwards, MD, of Richland Center
Assistant treasurer: John K. Scott, MD, of Madison

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William Wenger, of Madison
*ex-officio

Staff

Managing director: Julie A. Hein, of Madison
Administrative assistant: Jane Anderson, of Madison

It keeps more than memories alive.

THE AMERICAN HEART ASSOCIATION MEMORIAL PROGRAM

American Heart Association

This space provided as a public service.

CESF history

THE CHARITABLE, EDUCATIONAL and Scientific Foundation was chartered by the SMS in 1955 as a private, non-profit, non-stock corporation to enable physicians and other friends of the profession to support, through gifts and grants, projects vitally affecting scientific medicine and public health. The foundation's scope of interest has grown because of bequest contributions; therefore, a number of worthy programs affecting medical education and health care needs in Wisconsin can be accomplished. The future of the foundation holds an array of opportunities and challenges.

Benevolent assistance

The CES Foundation is ever sensitive to the needs of people who are the victims of adversity. Although the foundation's capacity in dollars has been limited, it has often been able to arouse the spirit of caring among physicians and the public when special needs arise. Assistance is looked at as an investment in the future and not as charity.

Education

Postgraduate teaching programs are a major thrust of the foundation. With CES Foundation support, the medical society's program of accreditation of continuing medical education, initiated in 1976, continues to move forward with increasing success. This effort has greatly expanded the availability of quality postgraduate learning opportunities for Wisconsin physicians and allied health personnel.

Funding from the foundation's Barbara Scott Maroney Memorial Fund for Research on Diabetes support special research projects, summer camp scholarships for diabetic children, publication of scientific articles or presentation of scientific speakers on the subject.

The foundation makes grants available to organizations striving to stimulate student interest in science and expose them to wide varieties of science related careers. Annually, the CES Foundation recognizes outstanding achievements in student science research by high school and middle school students in Wisconsin through contributions for awards to the Wisconsin Science Congress and the Wisconsin Science Olympiad.

As a project of the county auxiliaries, the Workshop on Health, a health education program for high school students, has featured such topics as anorexia nervosa, eating disorders, sexually transmitted diseases, teen suicide, alcohol and

Foundation grant allocations

THANKS TO THE EFFORTS of a tremendous number of physicians who have been entrusted with the responsibility of sharing the cost of providing financial contributions, the foundation is supporting a greater number of programs on a broader spectrum.

The list of grants provided by the foundation during this past year spells substantial achievement. Through physician support and leadership, the foundation hopes to encourage similar support from others. With education as its vanguard, the CESF prides itself in supporting medical education programs.

A special project of the CESF has been coordinated in conjunction with the Center for Public Representation. A booklet titled: *Medical Debt: How to Pay Hospital and Doctor Bills* is being well received as a useful resource for consumers.

The CESF also helped to sponsor two conferences: Wisconsin Research Network, a workshop for family physicians to discuss and hear presentations about office based, primary care research throughout Wisconsin; and Breast Cancer Update, a conference hosted by the Meriter Hospital Women's Center, addresses all facets of outcome of the disease, as well as the patient's reaction to family members coping.

The CESF sponsored an exhibit "Hands on Health" at the Madison Children's Museum to help expose children to medicine and perhaps stimulate a career in health care. Annual support is given to Doctors Ought to Care for the anti-tobacco poster contest for children in the Dane County school districts.

The foundation also provided a training grant to the Midwest AIDS Training and Educational Center. A booklet titled *An Accessible Entrance* for the handicapped published by Design Coalition, Inc was another project supported by CESF.

Each year at the SMS annual meeting, the CESF awards two Houghton scholarships for the outstanding senior at the University of Wisconsin-Madison Medical School and the Medical College of Wisconsin. The foundation also supports the *Wisconsin Medical Journal* by granting an award to one of the recipients of the *WMJ* Medical Writing Contest.

The foundation has continued to give grants toward the sciences. Support was given to the 1991 Wisconsin Science Olympiad and Wisconsin Science Congress.

The Wisconsin Safety Patrols, Inc rewards the efforts of outstanding safety patrol members by sending them to our nation's capitol. The foundation sponsored a delegate to this 5-day tour.

For further information regarding the CES Foundation, please contact Julie A. Hein, CES Foundation, PO Box 1109, Madison, WI 53701; 608-257-6781.

drug abuse, and wellness.

Student loans, grants and scholarships. One of the most important activities of the CES Foundation is the student loan program. Established in 1955, the foundation's general student loan fund is designed to assist needy, deserving students preparing for careers in medicine, dentistry, pharmacy, nursing, and other allied health fields. Long-term, low-interest loans are interest-free until after the student graduates. Personnel in the financial aid departments of Wisconsin medical schools cooperate with the foundation in identifying needy and deserving students.

Many young men and women can achieve their medical careers only because of the availability of large, low-interest loans. In fact, the average medical student today can anticipate graduating with debt obligations ranging from $50,000 to $75,000. Through fiscal year ending June, 1991, the foundation granted 57 loans to medical and allied health students for a total of $132,885. Repayments during fiscal year 1990-1991 totalled $76,167.00. Since the loan fund was established, 1,120 students have received $1,643,459.00 in long-term, low-interest loans.

Although the foundation's primary emphasis is in loans, some outright scholarships and grants are made to fulfill the wishes of some donors and the needs of certain potential recipients. These special health career student loan and scholarship funds are administered by the foundation according to the wishes of the individual or organization establishing and supporting the fund.

For example, a county medical society auxiliary may make an original endowment to the CES Foundation to establish a student loan or scholarship fund in the county auxiliary's name. The county auxiliary, as the benefactor may work with the foundation to determine what restrictions, if any, are to be placed on the loans. Such restrictions may include residency requirements, career specifications, educational facility, limitation on year of study, and dollar amounts.

Applications may be procured from the CES Foundation, 330 E Lakeside St, Madison, WI, 53715; or the medical college's financial aids offices. The CES Foundation furnishes an annual accounting to the benefactor or sponsoring organization.

To inquire how you or your organization can establish a special student loan or scholarship fund, contact Julie A. Hein, PO Box 1109, Madison, WI 53701; or phone 608-257-6781 (Madison area) or toll-free in Wisconsin 1-800-362-9080.[150th]

The Fort Crawford Medical Museum

The Fort Crawford Medical Museum is unique among educational and cultural institutions in the Midwest and the nation. Far more than a museum, it stands as a tribute to Wisconsin's physicians who have dedicated their lives to ensuring the health of the state's citizens. The museum is also a singular tool for educating the public about the prevention and treatment of injury and disease, the nature of medical care, the value of the physician-patient relationship, and the importance of keeping one's health.

The Fort Crawford military hospital, which has been designated a national landmark, and the related museum are located in Prairie du Chien near the Mississippi River. On this site in the 1830s, Dr William Beaumont carried out his famous experiments on the physiology of digestion.

The actual planning for the museum began in the 1930s when the SMS placed a granite memorial near the crumbling remains of the second Fort Crawford, which had been abandoned in 1872. In the mid 1940s, the SMS House of Delegates endorsed furnishing the hospital building as a museum. The property was deeded to the SMS Charitable, Educational and Scientific Foundation in the 1950s, and the SMS approved the completion of the museum complex, known officially as the Museum of Medical Progress. In 1964, the Stovall Hall of Health was added, which provided additional exhibit space.

In 1980, the Fort Crawford Medical Museum Endowment Fund was established to provide financial support for the museum. Over the years, more than 200,000 visitors have toured the museum, yet it continues to face financial hardship and is in need of frequent repair.

The first 500 persons who contribute $1,000 or more to the Fort Crawford Medical Museum Endowment Fund will join a select group known as the Beaumont 500 and will receive a specially designed Beaumont medallion. Currently, there are 66 members of the Beaumont 500 club with 18 established pledges.

The SMS Auxiliary and county auxiliaries have taken on the Beaumont 500 Club as a challenge project. Each county auxiliary is asked to pledge $1,000 toward the club over a specified time, probably 4 to 5 years, and challenge their county medical society to provide matching funds. Many of the auxiliaries and county medical societies have accepted this challenge.

During 1991, active promotion of the museum resulted in a growth in attendance and greater visibility for the site. The 1991 Civil War Encampment Weekend held in July also proved to be a success and attracted museum visitors from throughout the Midwest.

For more information about the Fort

Continued on next page

Continued from preceding page
Crawford Medical Museum, please contact Julie A. Hein at the CES foundation at 1-800-362-9080 or 608-257-6781.

Beaumont 500 members:
1980
Pierce-St Croix County Medical Society
1981
Mr and Mrs Robert B. Murphy
Guy W. Carlson, MD
W. Bruce Fye, MD
Pauline M. Jackson, MD
Dr and Mrs William D. Janssen
Dr and Mrs T. A. Leonard
E. J. Nordby, MD
Karver L. Puestow, MD
John D. Riesch, MD
1982
anonymous
Marion Crownhart
E. M. Dessloch, MD
Melvin F. Huth, MD
Michael F. Ries, MD
E. A. Steffen, MD
Kenneth M. Viste, Jr, MD
1983
W. Bradford Martin, MD
Earl R. and Alice Thayer
1984
Dr and Mrs K. Alan Stormo
Dr and Mrs Chesley Erwin
Dr and Mrs Leonard B. Torkelson
Leland C. Pomanville, MD
Mrs W. D. Hoard
Dr and Mrs Ralph Hudson
1985
Dr and Mrs Roger von Heimburg
Dr and Mrs Bertram H. Dessel
Mace Garrison Zinggeler
Dr and Mrs Benjamin Brunkow
Robert T. Cooney, MD
Staff of the State Medical Society of Wisconsin
1986
Dr and Mrs William Listwan
Richard W. Edwards, MD
Amy Hunter-Wilson, MD
Kari, Doran and Kenneth Viste
Roy Selby, MD
1987
Sandra Osborn, MD
Timothy T. Flaherty, MD
Washington County Medical Society
Dr and Mrs Roland R. Liebenow
Racine County Medical Auxiliary
State Medical Society of Wisconsin
1988
Jefferson County Medical Society
Milwaukee County Medical Auxiliary
Milwaukee County Medical Society
Dr and Mrs Victor Wong
Physicians Insurance Company of Wisconsin
Dr and Mrs Ken Smigielski
Kenneth M. Viste, Jr, MD, in honor of the SMS staff
Joan Flaherty
Edward A. Burg, Jr, MD, family
SMS Services, Inc
1989
Dr and Mrs Stephen Webster
Dr and Mrs Kermit Newcomer
Sauk County Medical Society
Wood County Medical Society
Dr and Mrs John D. Wegenke
La Crosse County Medical Society Auxiliary
1990
Green County Medical Society
Winnebago County Medical Society Auxiliary
Dr and Mrs Louis Hacker
1991
Brown County Medical Society Auxiliary
Dr Robert and Roberta Baldwin
Cyril M. Hetsko, MD and Theresa M. Hottenroth
Dr and Mrs J D Kabler
State Medical Society of Wisconsin Auxiliary

Beaumont 500 pledges
Columbia, Marquette, Adams Medical Society
Dodge County Medical Society Auxiliary
Eau Claire, Dunn, Pepin Medical Society Auxiliary
Fond du Lac County Medical Society Auxiliary
Green Lake-Waushara County Medical Society
Dr and Mrs Gerald C. Kempthorne
Kenosha County Medical Society
La Crosse County Medical Society
Manitowoc County Medical Society Auxilary
Oconto County Medical Society
Sheboygan County Medical Society Auxiliary
Trempealeau-Jackson-Buffalo County Medical Society
Vernon County Medical Society
Waukesha County Medical Society Auxiliary
Dr and Mrs David Weber
Winnebago County Medical Society
Thomas and Diane Adams
Dr and Mrs Raymond C. Zastrow[15th]

A CESF guide to gifts

Gifts to the foundation may take a number of forms: cash, bequests, trusts, life insurance, real estate, stock or other securities–some physicians are making the foundation a beneficiary of their wills. Such gifts may be designated as unrestricted or for specific immediate use at the discretion of the foundation trustees. They may also be restricted or earmarked for specific purposes of interest to the donor. Likewise, these gifts may also be designated for permanent investment with only the income used to support foundation programs. The foundation currently asks for a voluntary donation of $50 from the SMS membership through the membership dues statement and other direct mail solicitations.

Contributions provide financial aid to Wisconsin students of medicine and allied health professions, sponsors postgraduate teaching programs, stimulates research into areas of medicine and public health and promotes the preservation of medical history.

Cash gifts

Most gifts received by the foundation are in the form of cash, personal checks made payable to the CES Foundation. These gifts, as well as others, may be designated in honor of a relative, friend or associate. The foundation maintains a memorial program which gives the donor an opportunity to remember someone through a gift to the foundation–a living memorial. A memorial card is sent to the family with the name of the deceased and the name of the donor. The amount of the gift is not indicated. The donor will receive a card thanking them for their donation.

Bequests

A bequest is the giving of property by will. The will is designed to assure that upon death the property is distributed exactly in accord with the donor's wishes. One of the purposes of a will can be to perpetuate the donor's name or that of a friend through an organization such as the CES Foundation.

A codicil is an amendment or revision of a previously executed will. An attorney can draft it with minimal cost should donors wish to add a bequest to the CES Foundation to their will.

Gifts of life insurance

Life insurance offers an easy means to make a substantial gift as well as to provide tax advantages for the donor. A policy can be assigned to the foundation whether it is paid up, partially paid up, or new. Proceeds from such policies may be exempt from estate taxes and if the assignment is irrevocable, present values and future premium payments may qualify as charitable contributions for income tax purposes. The gift of life insurance is deductible, usually at its cash surrender value, at the time of transfer to the foundation. Arrangements may also be made to provide life income for a beneficiary by having the proceeds placed in a gift income plan with the proceeds placed in a gift income plan with the proceeds, following the life of the beneficiary, to go to the foundation. This plan also gives donors the satisfaction of making contributions and being recognized for it during their lifetimes.

Real estate

Any standard form of warranty deed or acceptable quit claim deed may be used to deliver real estate to the foundation.

Stock or other securities

Current gifts may take the form of stock or other securities which have appreciated in value. Gifts of appreciated securities permit the donor to realize substantial tax advantages.

Personal property

Some donors prefer to make gifts of art, jewelry, antiques, rare books, furniture, or collectibles of other types such as stamps, coins, etc. For tax purposes, the donor must determine the value of a personal property gift on the date of its transfer to the foundation.

Trusts

Some find it advantageous to make a contribution to the foundation, but retain the income from the contribution for the duration of their life or the lives of others. There are important tax advantages to these arrangements. The trustee of such "living trusts" may be a bank, trust company or the foundation.

Among the several types of living trusts are: annuity gifts; pooled income gifts; unitrust gifts, deferred payment gift annuities, revocable life income plans.

The CESF is pleased to announce the establishment of a Pooled Life Income Fund. This planned giving opportunity permits the donor to combine the advantage of bequests and lifetime gifts in one package. The gift is combined with other similar gifts which are held in a fund; hence the name pooled.

Participants or their beneficiaries will receive interest income throughout their lives. Upon the death of the investor's last beneficiary, the CESF will receive the principal to reinvest or use for whatever purposes.

If you are interested in the living trust program, you are urged to contact your legal adviser, accountant, or Julie A. Hein in the CESF office at 608-257-6781, or (outside Madison) 800-362-9080.

Display advertising sells!
Call the *WMJ* for a rate card
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608-257-6781

Access to Food Constitutes a Human Right

World hunger is an ever-present scourge that claims 35,000 lives each day.

Access to food constitutes a human right. In 1976, the United States Congress passed a Right to Food Resolution which declared the sense of the congress to be "that all people have a right to a nutritionally adequate diet".

Physicians Against World Hunger (PAWH), a non-profit, tax-exempt organization was founded so that physicians could collectively defend this human right by raising funds to support well-recognized, reputable organizations that are directly engaged in working with the poor primarily for the purpose of ending death by starvation.

Please join us — together physicians must help bring an end to world hunger.

Physicians Against World Hunger
#2 Stowe Road, Peekskill, NY 10566

❒ YES I wish to join PAWH in the struggle to end world hunger — enclosed is my contribution.

❒ $50 ❒ $100 ❒ $250 ❒ $500 ❒ Other _____

NAME *PLEASE PRINT*

ADDRESS CITY STATE ZIP

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Please forward your tax deductible contribution to Physicians Against World Hunger #2 Stowe Road, Peekskill, NY 10566

Madison, Wisconsin. Positions available: family practice and locum tenens in family practice (full time). Excellent salary, benefits, lifestyle. Contact Professional Staff Coordinator, Group Health Cooperative, 1 South Park St, Madison WI 53715; ph 608-251-4156. GHC is an equal opportunity/affirmative action employer. 6-7/92;tfn/92

Family practice. Seven doctor multi-specialty clinic in central Wisconsin needs another family practitioner. Outstanding financial package and benefits. Contact Peter McNally, Medford Clinic, 101 N. Gibson, Medford, WI 54451 (715-748-2121) or Russ Roskens, Wausau Regional Healthcare, Inc, 3000 Westhill Dr, Suite 202, Wausau, WI 54410; ph 715-847-2995. p7-8/92

Wisconsin. Family practitioner needed by a growing practice of a four physician group in a friendly rural community in northeast Wisconsin near Green Bay. This is an excellent opportunity to join an established organization. Highly competitive salary with benefits. Please contact: Artwich Clinic, Oconto Falls, WI 54154. p7-12/92

Pathologist. Locum tenens. Long term locums position available with an active hospital based group in southeastern Wisconsin. Please reply to Pathologists, PO Box 62, Elm Grove, WI 53122. 7-9/92

Family practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr Paul Hayes' office (906)563-9255 or Dr William Gladstone's home (906)563-8743. Anderson Memorial Hospital, Main St, Norway, MI 49870; (906)563-9243. 7/92

Ideal internal medicine practice. Excellent opportunity for BC/BE internist to establish a prosperous practice. Progressive 107-bed community hospital with a medical staff of 45 physicians and a service area population of over 45,000. Vibrant northern Michigan community with all summer and winter recreational activities. Salary guarantee of $110,000 with excellent benefits. Send CV or contact: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Ave, Iron Mountain, MI 49801; (800)323-8856. 7/92

Family practice physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD, MBA, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 7-9/92

Oshkosh, Wisconsin. Medical groups are recruiting in internal medicine, pulmonary, rheumatology, gastroenterology, OB/GYN, family practice, child psychiatry, and ophthalmology. Mercy Medical Center has an active medical staff of 100 physicians in all medical specialties. Oshkosh is an attractive community of 55,000 people, located on the shores of Lake Winnebago and in the heart of Wisconsin's beautiful Fox River Valley (metro area of 400,000 people). University of 12,000 students. Competitive financial packages. Contact Christopher Kashnig; Mercy Medical Center, 631 Hazel St, Oshkosh, WI 54902. Call 414-236-2430 or 800-242-5650, extension 2430. 7-9/92

Southeast Wisconsin. Well established, 39-physician multi-specialty group is seeking an energetic, motivated family physician. Unlimited potential. Full scope of family practice cases. No obstetrics. This progressive community offers exceptional recreational cultural and educational opportunities. Lake Michigan is at your doorstep. Position carries a competitive first-year guaranteed income and excellent benefit package. Contact Bob Suleski, 250 Regency Court, Waukesha, WI 53186; 1-800-338-7107. 7-9/92

Wisconsin. Fourth BC/BE obstetrician/gynecologist needed to join table, progressive, primary-care based HMO/group practice in university town of 60,000 near Minneaplis/St Paul. Excellent quality of life and outstanding recreational area. Competitive salary and fringe benefits. Contact Stuart R. Lancer, MD, MBA, Medical Director, Group Health Cooperative, PO Box 3217, Eau Claire, WI 54702; 715-836-8552. 7-9/92

Family practice - Internal medicine to join seven BC family practice physicians and one BC general surgeon in beautiful northern Wisconsin. Clinic facility is attached to hospital and new nursing home. Resort area. If your family life and life style are important to you, this is the opportunity. Contact Stephen Carlson, MD, or Jeanne Chamberlain, Adm, Northwest Medical Center, 707 Ash Street, Spooner, WI 54801; ph 715-635-2151. 7-12/92

Clinic physician. Seeking a licensed physician MD to provide patient care for an outpatient tribal clinic in Black River Falls, WI. Excellent facility with adequate staff. Work hours are Monday through Friday, 8 am to 5 pm 40 hours per week. No on-call duty. Minimum salary $84,000 DOE plus generous benefits including malpractice insurance coverage. Send resume/CV on or before July 31, 1992 to Ms Lorraine Carrimon, chair, Clinic Physician Search Committee, Wisconsin Winnebago Health Authority, PO Box 358, Mauston, WI 53948. 7/92

RATES: 55 cents per word, with a minimum charge of $25 per ad.

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DEADLINE: Copy must be received by the 1st of the month preceding the month of issue; *eg,* copy for the August issue is due July 1.

SEND TO: *Wisconsin Medical Journal,* PO Box 1109, Madison, WI 53701. FAX:608-283-5401. Classified ads are not taken over the telephone, but questions may be directed to 608-257-6781 or toll-free 1-800-362-9080.

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Mequon, WI 53092

Physicians Exchange

Continued

Milwaukee area. A rapidly expanding 60 physician multi-specialty clinic, seeks BC/BE physicians in the following special specialties: **family practice, internal medicine, ob/gyn, urology, psychiatry and oncology.** Competitive salary, excellent fringe benefits. Address inquiries and CV to : Administrator, PO Box 427, Menomonee Falls, WI 53052-0427. 6-8/92

Madison, Wisconsin. Positions available. Family practice, locum tenens (full time). Excellent salary, benefits, lifestyle. Contact Linda McLeod, Professional Staff Coordinator, Group Health Cooperative, One South Park St, Madison, WI 53715; ph 608-251-4156. GHC is an equal opportunity/affirmative action employer. 6-7/92

Physician wanted in a rural practice opportunity with four other physicians. The clinic is adjacent to the Wild Rose Community Hospital. Both clinic and hospital have a strong common interest in providing quality care. We would appreciate an opportunity to meet with you and discuss matters of compensation, benefits, etc. Please contact: Dan H. Fifield, MD, PO Box 314, Wild Rose, WI 54984. 5-8/92

Immediate opening. One general practitioner and one psychiatrist at a 230 bed acute treatment psychiatric hospital, JCAHO approved, Medicare certified, affiliated with the University of Iowa Medical College. **Forty-hour work week. No night or weekend on call.** Situated in picturesque northeast Iowa near large cities with cultural advantages. Ideal for family living. Golf club, hunting and fishing area, good schools, etc. Salary to $101,316.80. State law protects employees against malpractice. State pension plan. Unique deferred annuity plan. Generous sick leave and vacation. Write or call collect: B.J. Dave, MD, Superintendent, Mental Health Institute, Independence, Iowa 50644; ph 319-334-2583. 5-10/92

Iowa! Internists. Come grow with us! Sixty-five physician, multi-specialty clinic with physician-owned HMO needs four BC/BE internists to join 12. Above average income potential, excellent call schedule, friendly, family lifestyle on the Mississippi river. Just a stone's throw from beautiful southwestern Wisconsin. Excellent educational, cultural, and recreational opportunities. Call or write Denis Albright, Director of Physicians Recruiting, Medical Associates Clinic, PC, 1000 Langworthy, Dubuque, IA 52001; ph 319-589-9981. 5-7/92

Pediatrics, general surgery, family practice - Wisconsin. Single specialty groups seek B/E or B/C physicians for partnership in exceptional south central community. shared call, fully equipped and staffed office, very competitive guaranteed salary, and comprehensive benefit package. For information on this and other opportunities in the Upper Midwest, send CV to: Mary Jo Cordes, President, MDsearch, PO Box 21507, St Paul, MN 55121; or call collect 612-454-7291 or FAX 612-454-7277. 5-8/92

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Emergency medicine-Wisconsin. Emergency department medical director and staff positions are available at several client hospitals in Wisconsin–Portage, Watertown, and Superior. All newer emergency departments with a wide range of specialties represented. Progressive hospitals with excellent nursing staff support. Annual ED volumes range from 8,000 to 10,000. Metropolitan areas only 45 minutes from all facilities. Fee-for-service contracts, reimbursement for Wisconsin Compensation Fund. Medical directors also offered full benefit

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Physicians Exchange

Continued

package, administrative stipend, and participation in retirement plan after 12 months of service. For complete details on available opportunities in Wisconsin, contact Mallarry Dierkes, Spectrum Emergency Care, PO Box 419052, St Louis, MO 63141; 1-800-325-3982, ext 1029. 5-7/92

The Wausau Medical Center is seeking board certified/eligible individuals in the following specialties: dermatology, family medicine, gastroenterology, hematology/oncology, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year-round as well. Write or call collect D. K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401; ph 715-847-3254. c1tfn/91

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Internist to join two internists in active practice in scenic Upper Michigan. Medical school affiliation. Contact North Shore Internal Medicine, 2420 First Ave South, Escanaba, MI 49829; ph 906-786-1563. p11tfn/91

Internist to join a progressive 13-physician group practice. Rural college town 30 miles from St Paul, Minnesota, new clinic and constructing new hospital. Contact: Robert B. Johnson, MD, River Falls, WI 54022; ph 715-425-6701. c9tfn/91

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Medical Meetings-Continuing Medical Education

August 5-9, 1992: 43rd Annual Meeting International Doctors in AA (IDAA) in Grant Rapids, Michigan. Registration information: Connie Hyde, 3311 Brookhill Circle, Lexington, KY 40502; ph 606-233-0000; 606-277-9379; 606-253-0864 (FAX). g3-7/92

September 25-26, 1992: *Issues in Primary Care*, at Landmark Inn and Resort, Egg Harbor, Wis. Info: Nadine Punke,Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449; ph 1-800-782-8581, ext 5207. 6-8/92

October 15-18, 1992: 44th Annual AAFP Scientific Assembly in San Diego. Info: AAFP, 8880 Ward Pkwy, Kansas City, MO 64114; ph 816-333-9700; 816-822-0580 (FAX). g3-9/92

November 8-12, 1992: Ninety-Sixth Annual Meeting of the American Academy of Ophthalmology at Dallas Center. Contact: The American Academy of Ophthalmology, Meetings Dept, PO Box 7424, San Francisco, CA 94120-7424; ph 415-561-8500. g3-9/92

Medical Meetings-Continuing Medical Education

AMA

December 6-9, 1992: Interim House of Delegates, Nashville.

June 13-17, 1993: Annual AMA House of Delegates, Chicago.

December 5-8, 1993: Interim House of Delegates, New Orleans.

June 12-16, 1994: Annual AMA House of Delegates, Chicago.

December 4-7, 1994: Interim House of

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Physicians Insurance Company of Wisconsin 363
Post Graduate Medicine 371
Searle Company, G.D ..... BC
Calan®SR
SMS Services, Inc. 330
US Army Active 369
US Army Reserve 389
Wipfli Ullrich Bertelson CPAs 391
Wisconsin Air National Guard 357
Wynn O. Jones & Associates 341,342

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BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg*, copy for the August issue is due by July 1. Address communi-cations to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association*.

Specialty societies meetings - 1992

Wisconsin Society of Internal Medicine, Sept 17-19, Country Inn, Pewaukee

Wisconsin Surgical Society, Sept 25-26, Pioneer Inn, Oshkosh

Wisconsin Society of Pathologists, Sept 26, Froedtert Memorial Hospital, Milwaukee

Wisconsin Society of Otolaryngology, Oct 3, Heidel House, Green Lake

Wisconsin Chapter, American College of Emergency Physicians, Oct 29, Oshkosh

Wisconsin Dermatological Society, Nov 14, Milwaukee

Wisconsin Chapter, American College of Surgeons, Nov 13-14, Midway Motor Lodge, Brookfield

State Medical Society of Wisconsin

Dates and locations of
ANNUAL MEETINGS
1993-1994

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1993 - April 15-17: La Crosse Convention Center, Radisson
1994 - April 14-16: Milwaukee

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

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†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus.* New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol.* 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol.* 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation.* 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology.* 1988;39:1025-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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Contents

August 1992 Vol. 91 No. 8

Opinions

465 *President's page*
The bell tolls for us
by William J. Listwan, MD, West Bend
468 *Secretary's report*
Only vertebrates can reform health care
by Thomas L. Adams, CAE, Madison
470 *Letters*
Private practice is still the best practice
by Albert L. Fisher, MD, Oshkosh
470 Founding principles need rediscovering
by James P. Fogarty, MD, Barron
471 How do you know when you have enough doctors?
by Daniel T. Peterson, MD, Janesville
471 National health care won't cure social ills
by John J. Downing, MD, Janesville
472 *Soundings*
Hackers: a play in six scenes
by William Houghton, MD, Milwaukee

Scientific

477 Longitudinal study of semen quality in Wisconsin men over one decade
by Frank M. Wittmaack, MD and Sander S. Shapiro, MD, Madison
480 Operation Desert Storm: clinical experiences at the 13th Evacuation Hospital, a Wisconsin National Guard unit
by Yeu-Tsu Margaret Lee, MD; John D. Alvarez, MD; Janet A. Wilson, MD; and Lewis B. Harned, MD, Honolulu, San Antonio, Wisconsin Rapids and Madison
482 A spontaneous combined (heterotopic) pregnancy: a case report
by Michael A. Schellpfeffer, MD, Kenosha

Socioeconomic

485 Sheepskin rugs linked to crib death
by Timothy J. Chybowski, MD, Madison

Organizational

487 SMS returns to Racine; board action reported
488 SMS: Medical Assistance plan fails to improve access for OB services
490 *Dodge County doctors accept the challenge*
Anti-smoking campaign in grade schools is expanded in honor of the SMS' 150th
492 SMS task force looks at health care reform
492 Domestic violence poster distribution begins, campaign gains exposure
493 *Field of blood, field of the forgotten*
The Potter's Field of Milwaukee County
501 Physician briefs
504 Obituaries
504 CES Foundation donors

Our cover: Babies and sheepskins: a soothing combination or contributor to suffocation? See related article on page 485.

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The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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District 8
Robert L. Sellers, MD, Superior

President's page

The bell tolls for us

"No man is an Island, intire of it selfe; every man is a peece of the Continent, a part of the maine; if a Clod bee washed away by the Sea, Europe is the lesse, as well as if a Promontorie were, as well as if a Mannor of thy friends or of thine owner were; any mans death diminishes me, because I am involved in Mankinde; And therefore never send to know for whom the bell tolls; It tolls for thee."
–John Donne, *Devotions* XVII

William J. Listwan, MD

Recently, I had the opportunity to review a medical record that really bothered me. A review organization (specific name withheld to prevent bomb threats) said this case did not meet its criteria and the physician was being reprimanded. I felt the physician had done nothing wrong!

The accused physician wrote legibly, clearly identified his thought processes throughout the record, and had managed the patient intelligently by ordering only necessary tests. He had done an above average job of taking care of a difficult and complicated situation, but a urinalysis done during the hospitalization had shown a few white cells and many red blood cells. The physician spoke to this in his progress notes and indicated his reasons for feeling this was a contaminated specimen and not indicative of infection. I must admit I rarely write a note when I dismiss a laboratory test that I feel is not pertinent to the clinical setting.

When a second admission occurred a short time later, the patient was septic. A bacteria was grown from the blood stream and the same bacteria, although with different sensitivities, was grown from the urine. You guessed it: The physician was being censured for not adequately following up and evaluating a problem identified during the first admission that resulted in a second admission.

The reasonableness and documentation for not evaluating the initial abnormal urinalysis were ignored. The fact that the sensitivities on the blood culture and urine culture on the second admission were not the same was ignored. It was more expedient to assume bad care than to spend more time analyzing the situation.

My purpose is not to recount another "war" story. My purpose in sharing this with you is to point out that the bell is tolling, tolling for all of us. Scrutiny of our admissions, our medical records, and our patient care in the hospital will continue to increase. Soon our office care will be under day-to-day scrutiny as well.

Nothing irritates me more than to receive notification that the care of one of my patients is being challenged. It reflects on the quality of the care I provide

Continued on next page

Domestic violence seminar

A seminar titled "Domestic Violence: Identification, Treatment and Prevention" will be held Sept 19, 1992, at the Pfister Hotel in Milwaukee. This day-long program will be geared toward practicing physicians, nurses and other interested professionals. To register, contact: Amy John, Milwaukee Academy of Medicine, 414-257-8249.[150th]

Continued from preceding page
and I take it as a personal affront to my integrity and skills. It really rubs me the wrong way and makes me extremely argumentative and defensive. I certainly can't blame other physicians for feeling the same way.

Many times I wonder why we cooperate with, or do anything to encourage, outside review of our records. Review by my colleagues at the clinic, or even review by other physicians in my hospital, is tolerated better than review from outside organizations. Perhaps it's the fact that the review by outside organizations is much more impersonal or that the language used in the notification letters is inflammatory. But, even taking into account the fact that the reviewing physicians are limited to the medical records at hand, usually just a single admission, the criticisms frequently seem to be inappropriate and down right silly.

* * *

Recently, I had the opportunity to meet with the physicians and administrators who are responsible for the day-to-day functioning of our state peer review organization, the Wisconsin Peer Review Organization (WIPRO). Tom Adams and other State Medical Society staff were also present. I think the meeting was useful because we conveyed the frustrations of Wisconsin physicians to the physicians and administrators at WIPRO. I think we also came away with some understanding of the difficulties they are facing.

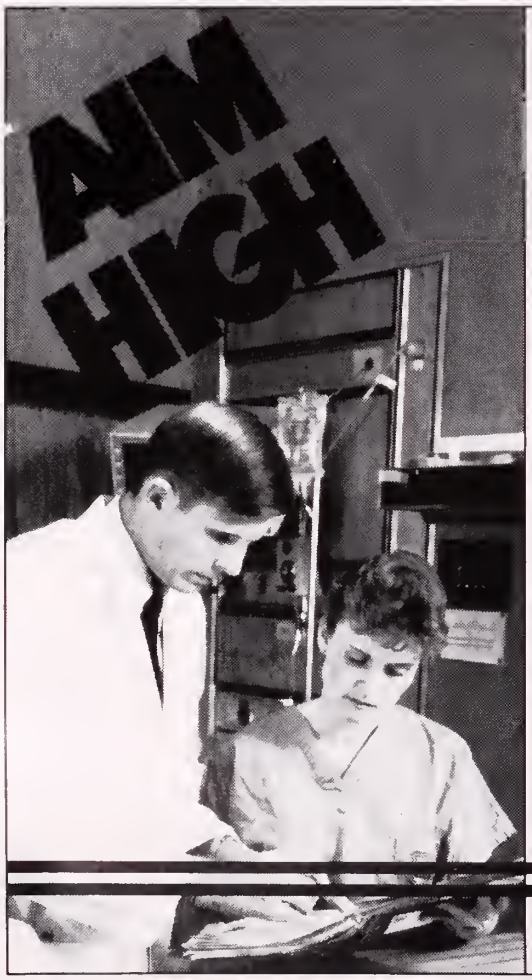
The administration of WIPRO was understandably defensive about past WIPRO decisions and activities. This brought home to me the necessity for good physician representation on the WIPRO board. After all, the board does have the final responsibility for WIPRO decisions, is composed of practicing physicians elected by other practicing physicians, and should be sensitive to and responsive to our concerns.

Did you review and return the WIPRO ballot this year? Last year less than 400 physicians did. Pay attention, see who's running, and vote thoughtfully. Better yet, consider running for the board or encouraging someone else to run who will represent your views on the board. All of you have the opportunity to participate in the election process.

This year, the SMS has encouraged three interested physicians to run for the WIPRO board. We feel that it is important that new blood be introduced to the board on a regular basis. This will help to keep the board fresh and responsive to the physicians of Wisconsin. I urge you to thoughtfully consider voting for Dr Maury Berger of Milwaukee, Dr Charles Link of La Crosse, and Dr John Utrie of Green Bay.

We also need to improve communication between the SMS and WIPRO. As an example, over the past 2 years, WIPRO had identified a number of minor deficiencies, which they call "Level I," and

Continued on page 468



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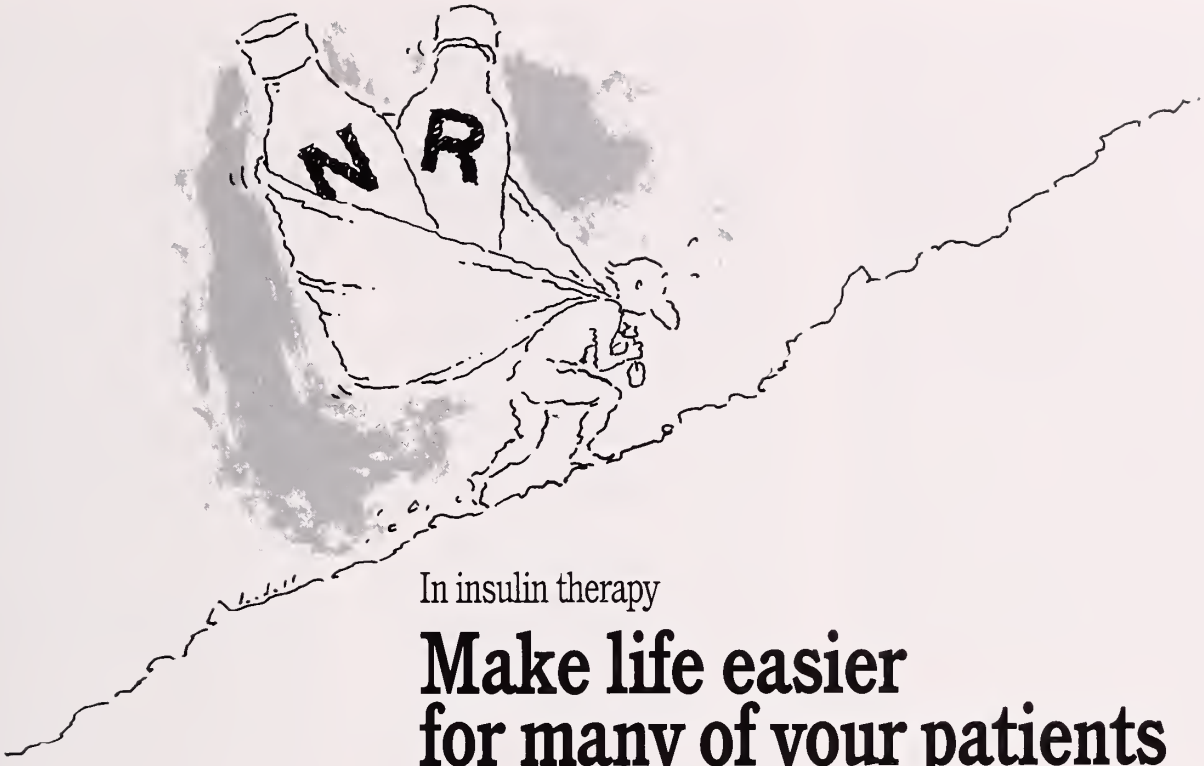

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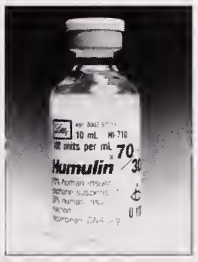

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Continued from page 466
had decided not to process them further. The Health Care Financing Administration (HCFA) in Washington told them they all had to be processed completely. Accordingly, there was a flurry of notifications around Wisconsin for minor deficiencies that dated back as much as 2 years. If WIPRO had informed the SMS in advance of the HCFA mandate, we could have informed our membership ahead of time. At least then individual physician anger could have been focused on the proper target.

Communication in other areas is also important. I think the SMS must keep the physician board members of WIPRO informed of the SMS position on peer review issues and to let them know what problems we are hearing about from our members. We must also communicate better on the staff level. Arrangements have been made for an exchange of staff so that some of our key people can learn more about WIPRO and how it functions. The SMS has also agreed to publish several articles about WIPRO to help increase the opportunity for physician understanding of WIPRO, how it is structured, and why it functions the way it does.

One of the biggest problems WIPRO has, and one that certainly impacts directly on my practice, is difficulty recruiting physician reviewers. Admittedly, the pay is nominal and the prestige limited, but without a choice of quality reviewers we are all doomed to the frustration of inadequate and inappropriate review by people who are not our peers.

There is a particular need for physicians in the specialties of internal medicine, general surgery, and cardiology to review medical records. Please take the time to learn more about this opportunity to help your colleagues, and to help yourself. Contact Trish Ramsay at the SMS at 1-800-362-9080 or, in Madison, call 257-6781 to get more information.

Regardless of whether we like it, peer review by outside organizations is here to stay. We need to do what we can to influence the direction that peer review takes and we need to understand the peer review process better. Remember, we're all in this together and we will either succeed or fail together. The bell tolls for all of us.

Adapted from: Listwan W. Listen to the bell tolling. *The Internist*, 1991; 32 (7):34.[150th]

Secretary's report

Only vertebrates can reform health care

The following opinion is reprinted from an editorial written by Thomas L. Adams, CAE, for the Wisconsin State Journal *in July.*

Perhaps the greatest struggles within the health care professions these days are the dual problems of increasing costs of delivering health care and the decreasing ability of patients to access the health care system. They are not ours alone to face. Because we all need health care at some point in our lives, and because we have all played a role in creating the problems, the struggle has spread to a wide spectrum of society.

The problems and proposed solutions are in the headlines and on the airwaves every week. Every politician up for reelection has a plan for health care reform, as does a host of social critics, economists and so-called consumer advocates. And, of course, doctors, nurses, dentists, chiropractors and hospital administrators all have ideas for improving the system.

Unfortunately, no other nation has found the answer either, so we have no example to follow. Contrary to what some well-meaning but misinformed folks are insisting, even the Canadian health care system is suffering from serious flaws of its own and does not give us a good model. Besides, there is an inherent danger in trying to copy institutions created by other cultures. Our world's cultural diversity certainly makes our lives richer and more interesting, but it also prevents us from simply shifting customs and institutions across borders.

For instance, the values of the Napoleonic code, dating back to prerevolutionary France, manifest themselves in Canadian thinking and-along with, I think, their larger space and smaller population--make Canadians more tolerant than Americans of government intervention in rendering or orchestrating the provision

Thomas L. Adams, CAE

of services (in this case, health care services). Our intellectual legacy of frontier individualism, disdain for centralized

power and faith in the forces of competitive markets to work in favor of the general good make us, as a people, ill-suited for a Canadian-style health care system.

It is the beliefs and values of our national psyche that determine the best way to dispense and pay for health care, not the other way around. Our health care system is only a small part of our social fabric and to work best it must fit that broader context of American culture.

This is not to say that we should don the blinders of nationalism and refuse to learn from others, only that we must fit what we learn to our own culture.

It is important, too, that we keep things in perspective. At no point in the history of the United States has health care been more available to more people. At no point in the history of medicine has our ability been greater to relieve suffering, to heal injuries, to cure diseases and to prevent health problems. We now enjoy the most advanced technology, the most sophisticated procedures, the most powerful medications and the most educated and able physicians.

In the midst of that brilliance, however, we acknowledge the health care delivery system's failings and accept the responsibility for change. In that effort, the State Medical Society joined forces with the Wisconsin Manufacturers and Commerce and the Wisconsin Hospital Association. Together, we forged a 12-point plan with bi-partisan support that would have, if the Legislature had possessed the courage to enact it in its entirety, fixed Wisconsin's two health care problems. Business and industry were willing to do their part, the health care professions were willing to do their part, but the majority of state legislators could not summon the political will to do their part.

The Legislature took on the easy questions but failed to address the tougher reforms: controlling our mercurial liability system, providing adequate funding of services provided to Medical Assistance patients, and fully facing the needs of 400,000 uninsured Wisconsin residents. Ultimately, these failures drive up the cost of health care. Sadly, the Legislature's lack of business sense also has adverse effects on the health of Wisconsin's residents. When children are not immunized, when women do not receive prenatal care, when families go without preventive care, when the elderly decide not to seek the care they need because they are uninsured or because the government-run program is under-funded, the toll of human suffering mounts–and the long-term cost of their care rises.

> 'It is the beliefs and values of our national psyche that determine the best way to dispense and pay for health care, not the other way around.'

The reforms enacted so far have been aimed primarily at curtailing costs by slowing advances in and growth of the health care system, but they are not enough. The costs of caring for the uninsured and MA patients, as well as the costs inspired by our tort system–defensive medicine and a 600% increase in liability insurance premiums over the past decade–remain uncontrolled. All of these costs cannot be absorbed by the health care system, particularly those parts of the system that serve inner cities and rural areas, so they must be shifted to other patients and their insurers and employers.

The Legislature's failure is rooted in its inability to withstand the lobby of Wisconsin's trial attorneys, who profit greatly from our current tort system, and in its inability to get beyond the traditional government budget mentality. The Legislature cannot see, for instance, that spending more on prenatal and preventive care now will actually cause it to save money by spending far less for curative care later. All it sees is an increased expenditure in the current budget, and it cringes. Until our elected leaders find the courage and foresight to deal with the tough questions, no meaningful reform will occur. Perhaps the state's new Task Force on Health Care Cost Containment will do what the Legislature failed to do. For the sake of Wisconsin's health, I hope it will.

The key to meaningful health care reform is the acceptance of responsibility by every facet of society. We must decide, as a people, that we are committed to providing health care to those who need it but cannot afford it, and then make the tough choices necessary to reach that goal. Physicians have accepted their role, but they cannot do it alone. We have all--business, government, consumers and health care workers–played a part in creating the health care system; now we must all play a part in reforming it.[150th]

Health care reform is nothing new

More than 4,000 years ago, the Babylonian king Hammurabi established socialized medicine and fixed the fees of physicians according to the means of the patient.

In 1500 BC, the citizens of Thebes were complaining that there were no longer any good old family physicians. Every one was a specialist. "The practice of medicine," writes Herodotus, the Greek historian, "is so divided among them that each physician is a healer of one disease and no more. All the country is full of physicians, some of the eye, some of the teeth, some of what pertains to the belly."

–*Milwaukee Journal*, Jan 17, 1952.[150th]

Letters

Private practice is still the best practice

To the editor: Following the recent House of Delegates session, it is time to reflect on where this medical society is going. The handling of Resolution 32 tells the membership a great deal. This resolution sought to inform the public about the negative aspects of the Canadian health care system.... The Canadian system has been a disaster by many important measures, including: rationing, loss of patient confidentiality, and massive intrusion of bureaucracy into the doctor-patient relationship.

Yet, our medical society did not adopt this resolution, and has called for a task force to study health care "reform." By now, we should recognize "health care reform" as code words for socialized medicine.... What we need is not further study, but action, to combat these socialist schemes.

Neither a snarl nor a whimper was heard from the delegates when the reference committee instructed them to vote down Resolution 32. No one had the backbone to stand up and remind everyone that private practice is the best way to practice medicine. Only in private practice are patients protected by independent physicians who are working for the patient. Under government medicine, medical care becomes politicized, and clerks dictate who can be seen, for what reason, what treatment can be used, and when (if ever). Government becomes the master, doctors become civil service employees, and the patients end up with a form of veterinary medicine.

Having grown fat feeding at the public trough, doctors now hesitate to inform patients of the nature of socialized medicine. Indeed, some of our leaders are urging us to "cooperate" with politicians, so we can shape health care "reform" to our advantage. Are they trying to tell us that if we "get in" at the ground level we might get our hands on even more taxpayer's money?

That is the essence of political action by organized medicine in the 1990s: support all cost shifting schemes and subsidies for doctors, but remain mute on issues of freedom, professional independence, and constitutional protections. Forget the Hippocratic Oath; maybe even forget all the reasons we entered this profession....

Our only hope is to begin weaning ourselves from government money, because with government money comes government control. Patients will accept direct billing from physicians once they realize that confidentiality and the personal relationship with their physician will be restored. We can get government out of the practice of medicine by going back to the traditional method of charging less for patients whose resources are limited and providing charity care for the poor. We must be willing to accept as full payment what the patients think the service is worth, rather than using the IRS as a collection agency. Attempts to control physicians' behavior through the abuse of licensure, excessive regulations, and heavy administrative fines should be aggressively attacked by the SMS. Once we have taken these positive steps, we will feel a lot better, and so will the patients. Then we can go before the politicians and announce, "we have the answer and it's called private practice."

–Albert L. Fisher, MD
Oshkosh

Editor's note: This letter has been edited for length.[150th]

Founding principles need rediscovering

To the editor: Americans, in the presidential election year, continue to demonstrate their dissatisfaction with not only the presidential candidates but the system of government they represent.

Special interest groups, such as "the rich" and mega-industry, have been promoted as the evil perpetrators of a system gone bad.

Cries of reform echo from various individuals to control campaign funding and special interest lobbying by having Congress regulate itself–in a sense, the fox guarding the chicken coup.

As a nation, we have evolved into a "find out who is to blame" society, rather than looking within ourselves for solutions to problems. As the cartoon character, Pogo, once stated, "We have met the enemy and they is us."

At a meeting in which a state representative was fielding questions, I sensed the main purpose of most individuals attending was to see of they could receive some sort of benefits from government. I also sensed that the representative was there to buy votes with proposals of government subsidies.

The scenario goes something like this: "My elderly mother has a fixed income and relies on interest rates to subsidize her income. With interest rates so low, isn't there something you can do through legislation to protect these rates from dropping?" State representative: "Why yes. A bill in Congress is being formulated to do just that."

Such an approach, multiplied many times over, has produced a basic attitude that government is here to provide and subsidize not only individuals but industry, agriculture, and the like. We have become a society programmed to receive

Continued on next page

How do you know when you have enough doctors?

To the editor: I recently spent time on a medical manpower planning committee for a community hospital.... A consultant from Chicago was enlisted to aid our deliberations. Since he was more than 50 miles from home, we all assumed he was an expert. After a couple of hours of charts, graphs, and slides, he produced a remarkably detailed list of doctors needed in the community–collated by specialist and subspecialist. Some of the numbers on the list did not make intuitive sense, so I began to question the mechanism used to determine manpower needs. At that point the numbers softened up substantially and the arbitrary nature of the projections became apparent.

The answer to how many doctors you need is determined by to whom the questions is put. If you ask doctors, they will probably say another doctor is needed when the most recently arrived practitioner is as busy as he wants to be. If you ask hospital administrators, they will say more doctors are needed until the hospital is full. If you ask patients, they will say more doctors are needed if there is any delay for an appointment. There is a conflict between waiting time for an appointment and efficient use of health care personnel: Immediate service can only occur if health care providers are standing around with nothing to do....

The question is not inconsequential. Training a physician consumes enormous public resources.... It would not be prudent to train more than we absolutely need. Of even greater importance, health care costs are more or less proportional to the number of doctors in town. Each new physician generates about a half million dollars a year in patient charges. The idea that increasing physician numbers reduces costs via competition is simply nonsense. The situation is analogous to a beaver pond in the forest. The number of trees cut down is proportional to the number of beavers that live there and has nothing to do with how many trees our smartest planners say need to be cut. Adding doctors is not the correct prescription for soaring health care costs. We need to explore unique and new solutions for health care delivery–such as increased use of physician-directed para medical personnel. This is a difficult project in today's climate of high patient expectations and a litigious society.

I would like to propose what unfortunately may be a new concept: make medical manpower decisions on the basis of quality of care. If the proposed recruitment improves the quality of patient care, do it with enthusiasm. If it does not, do not do it at all.... Quality includes many aspects: geographic accessibility, cost, volume sufficient to ensure competence, and the presence of requisite support services. It does not include protecting your "market area," services chosen for revenue production alone, or image building services.

Some may say it is naive to propose such a simple solution. If this is naive, the profession is in much deeper trouble than most of us suspect.

–Daniel T. Peterson, MD
Janesville

Editor's note: This letter has been edited for length.[150th]

Continued from preceding page
to such an extent that our national debt has reached $2.7 trillion and is rising at $1 billion a day.

The success of this nation was carefully planned by our forefathers to clearly establish government's role and limits. It held steadfastly to the principle of individual rights that provided the media for self reliance resulting in the highest standard of living in the world.

We must rediscover our government's role and elect representatives who have the vision to follow these principles. If not, this nation will collapse under government's present role of providing for society.

–James P. Fogarty, MD
Barron[150th]

National health care won't cure social ills

To the editor: In the June issue, Dr Steven Weiss wrote an interesting article concerning a call for a national health care funding system. He points out that the United States spends approximately 12% of the GNP on health care, but has high infant mortality rate. The implication is that the health care system is in a major way responsible for the high infant mortality rate. Is it not possible that other factors can contribute to a high infant mortality rate?

Some would argue that the break down of the family in the inner cities, drug use by expectant mothers, and other factors have a greater effect on the health of infants born under these conditions.

It is hard to argue with Dr Weiss about the wisdom of funding expensive liver transplants in alcoholics, when it is possible that the money may be better spent for prenatal programs.

The article goes on to point out that at the Minneapolis Hennepin Medical Center, there are 56 people employed in the finance department, whereas in Ontario's Toronto Hospital, which is a larger facility, only 22 people are employed in billing. This indicates that a national health program may indeed result in some cost savings by reducing administrative personnel. Dr Weiss, however, fails to mention that to support a national health

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program the people of Canada must pay a fairly high tax of approximately 15% on virtually every item purchased. Because of this high tax, a number of Canadians who live near the United States border, travel into this country to buy basic goods.

In summary, any national health care proposal will have certain advantages as well as disadvantages. It seems unlikely to me, however, that the enactment of a national health care program will eliminate problems that are deeply rooted in certain segments of the United States population, such as drug use, chronic unemployment, crime, and infant mortality.

-John J. Downing, MD
Janesville

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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Soundings

Hackers: a play in six scenes

What follows is a fantasy about the selling of the American health care thing. It is purely fictional, and the characters bear no resemblance to persons living or dead, only to certain universal human qualities. What actually happens in the corridors of power is unknown, being necessarily private and a trade secret. The purposes of a fiction like this are to suggest a motive and to show how all people make their way in society–each doing his own honest thing–and thus create the monster of society.

In our American democracy, special interest groups carve the meat, and each takes the best piece he can.

The author sincerely apologizes that there is something here to offend every faction. He is only following the ancient medical tradition of offering a Physic: an evil-smelling concoction that is a health-giving Purge. To your health! Bottoms up!

Scene 1. (The scene is the office of a large insurance company. The room is huge. There is enormous carpeted space around the desk and chairs. The air has the clean smell of pure computer data, in fact no smell at all.)

Theodore Williams (president of Fidelity HMO):
We have contracts lined up with 50 Fortune 500 companies, and we want to put together the biggest, most efficient, highest class act HMO in the nation, starting out here in the heart of the Midwest.

Buck Blazer (director of marketing, fresh from presidential campaign):
I got you, and I believe that with proper marketing and image control we can do it.

Ted Williams:
Fidelity HMO will offer the conventional range of medical services–sports medicine, transplant surgery, weight control, and maybe an infectious disease department–but listen to this for an innovation in healthcare delivery: We can carve out a specialty area, say in bypass surgery, hip replacement, or laser surgery. We contract with the top surgeons in those areas, then we sell that procedure to all the top companies, and to other HMOs, too, and sew up the field.

Buck Blazer:
Reduce overhead, drive out the competition and build up the image of our world-class program?

Ted Williams:
Exactly. A Master Craftsman program.

Buck Blazer:
It's sweet, it's gonna fly, that sucker will be a screamer.

Ted Williams:
Last quarter we were up 20%. If genetic engineering sells well on the stock exchange, and Ivy League presidents open chains of franchise schools, then there is no reason that Fidelity HMO can't be as big as Toyota. Alain Enthoven and the *New York Times* recommended managed competition, and this is it.

Scene II. (Dr Herb Wallner, the president of the ISMG–Inner Sanctum Medical Guild–is meeting with the Fidelity HMO

staff at the company headquarters. He is dressed with unstudied neglect, in a baggy sport coat and forgettable tie. The doctor looks clumsy but strong.)

Ted Williams:

It's a pleasure to have you with us, Dr Wallner.

Dr Herb Wallner:

It's our role at the medical guild to interact with the business community as well as with the public. What can I do for you?

Ted Williams:

We are currently developing a broader-based HMO, we are expanding into other areas, and we would like to let your professional organization know about this, with a view toward your encouraging your members to participate.

Dr Herb Wallner:

I'm not sure I can do that, but we will certainly appreciate being informed. Some doctors have had the reputation of being stuffy and standoffish, and we certainly would not want to look that way.

Ted Williams:

We go back over 15 years, Herb. Anyhow, Fidelity HMO is expanding to 200,000 contract holders, and we hope to go outside the state, too.

Buck Blazer:

It's going to be sweet, Doc, it'll fly. Now here's the concept.

Ted Williams:

A unique feature of Fidelity HMO will be areas of what we call Master Craftsmanship: The idea is that we'll carve out an area of specialty service, say coronary bypass surgery, we'll contract with the best bypass surgeons in a five-state area–we might even have surgical centers in two cities–and then we'll sell that specialized service to all contract holders, and even to HMOs other than our own. What do you think?

Buck Blazer:

That baby's gonna move, Doc, it's going to burn rubber, it's a Lamborghini.

Dr Herb Wallner:

It is an interesting idea, Ted. I don't think I have ever heard of specialization being carried that far, but doesn't it kind of work against the original concept of an HMO, with services scattered to multiple sites?

Buck Blazer:

Don't get hung up, Doc, it gets better, it gets much better.

Ted Williams:

Scattered? How do you mean?

Dr Herb Wallner:

Well, if a patient has diabetes and coronary artery disease, he might first go to his internist. Then when his coronary artery disease is worked up, he'd have to be transferred to another hospital, sometimes at a remote place. Couldn't there be problems with that? Essentially, what if there is one patient with problems in two organs, and the Master Craftsman services for those organs are in two cities?

Ted Williams:

I see what you mean, but how often does that kind of thing happen? This is a system that is going to demand top-notch communication and teamwork.

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Buck Blazer:

Those Flight for Life helicopters are under-used. I can see a tie-in there. The fax and modem can do the communication. In 10 years, they'll be doing remote control robot surgery. I think if you look into it you'll see it's going to get better, much better. It'll knock your socks off.

Dr Herb Wallner:

I hope so, but I have some doubts.

Ted Williams:

The secret of health care delivery is to put large bunches of similar patients together. Like Walmart. You can treat them cheaper.

Dr Herb Wallner:

I would have thought it was important to treat each person as an individual, a unique combination of disease and quirks and strengths. I can recall when the community of health care givers used to have an organic unity, to some extent. It wasn't split up among corporation. And what will happen to Fidelity if national health insurance is instituted?

Ted Williams:

That'll be no problem. We have connections, we offer the best, we'll be first in line for the government contract.

Buck Blazer:

We can go either way. There's always a place for good

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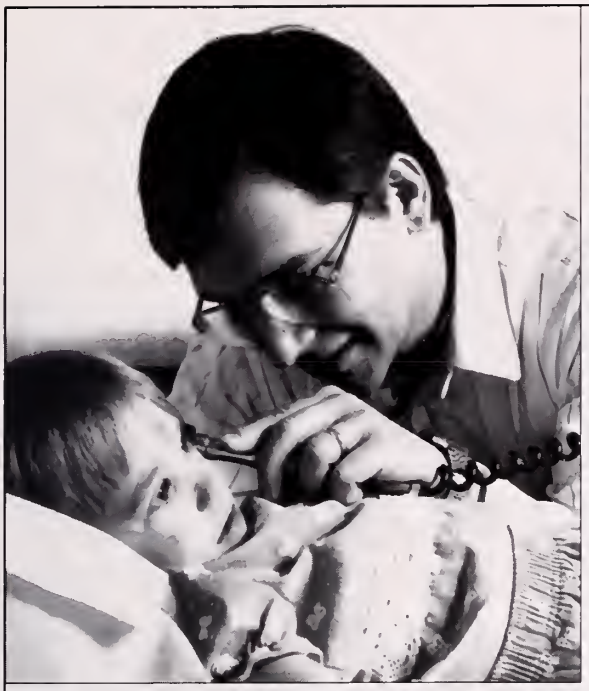
business. Ever hear of defense contracts? If the government wants to get into it, so much the better. Let others react–we proact.
Dr Herb Wallner:
I see.
Ted Williams:
Will you let the members of the Medical Guild know about our plans? And you can let them know that we will be interested in writing extremely generous contracts with specialists in all areas.
Dr Herb Wallner:
I guess I may be old and out of step. We used to regard the human body as a wonderful unity, almost sacred. There is just one warning I can leave you: If you ask doctors to compete for cash, pretty many of them may very well do it, so you may want to think it over. (He leaves.)
Buck Blazer:
Doctors *are* stuffy and stand-offish. Ever notice how they always come up with a criticism? I can never tell what their pitch is.
Ted Williams:
I know what you mean, but Herb Wallner is a good man and he pretty well represents the doctors in this state.

Scene III. (Dr Goodheart, a private practitioner, comes to Fidelity HMO.)
Dr Goodheart:
Research shows a high percentage of the population have difficulties in getting along and adjusting to the vicissitudes of life, and the best way to help that process–which may also result in fewer days of illness, fewer days in the hospital, and reduced need for other medical treatment–is to provide a network of readily accessible outpatient counseling services. We'd like to help the emotionally distributed in that way.
Ted Williams:
Thank you for your interest, Dr Goodheart, but the Fidelity HMO will have only limited counseling benefits. We are making some arrangements with other parties. It is curious that you would want to reduce illness and other medical treatment. Thank you for coming. (They leave.)

Scene IV. (Dr Julian Raven, a psychiatrist in a turtleneck shirt and tweed coat, and carrying a pipe comes to Fidelity HMO.)
Dr Julian Raven:
I'm Julian Raven, a psychiatrist from the Riveredge Wellness Center.
Ted Williams:
What can we do for you?
Dr Julian Raven:
We have heard about the Fidelity HMO, and would like to find out more.
Buck Blazer:
It's a peach, you'll love it.
Ted Williams (making some variations in his explanation): We plan to provide a full range of medical services, including mental health and AODA, and we are setting up areas of specialization with multi-state centers, for hip replacement or coronary bypass operations, for example. I must admit I don't know much about psychiatry. Dr Goodheart was here, and he didn't help too much. I do know the expense has gotten way out of hand–can you tell me what you do?
Dr Julian Raven:
Depression strikes one out of two Americans. We can fix it with an antidepressant. Neurotransmitters are my own personal bread and butter. I could do a Psychopharmacology Clinic for you.
Buck Blazer:
That sounds great, and it might pick up our spirits too, ha ha. I'll bet you guys wish you got in on the ground floor with that Prozac–that was a sweet deal.
Ted Williams:
Psychiatry can be useful for severe cases. The cost of hospital beds is scandalous, however, and those therapies that go on for years are beyond belief. Dr Goodheart was here with his bleeding-heart counseling. I'm not sure we need too much of that at Fidelity.
Dr Julian Raven:
We don't do that couch stuff anymore. It's too slow and boring. I understand your concern about expenses. We might be able to help you with some utilization review criteria that will really cut costs.
Buck Blazer:
Any chance you can do some transplants?
Dr Julian Raven:
We're working on a refined amygdalectomy, sort of an update on the lobotomy.
Buck Blazer:
Nah, that's gonna be hard to sell.
Ted Williams:
Are there any other special features to psychiatry?
Dr Julian Raven:
All of our diagnoses are capitalized–no other specialty can make that claim. I'd like to also mention that we stand for biopsychosocial values.
Buck Blazer:
What's that?
Dr Julian Raven:
We try to understand the patient's emotions, where he is coming from, and his social milieu.
Buck Blazer:
Oh, like Bush's vision thing?
Dr Julian Raven:
Well, sort of–
Buck Blazer:
It didn't work too well for Bush.
Ted Williams:
One thing I have to emphasize: We always have trouble with psychiatric patients. It's their elastic and unpredictable
Continued on page 476



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Continued from page 474
needs.
Dr Julian Raven:
That can be controlled by careful case mix and management.
Ted Williams:
I suppose that's so, but somehow they seem more unreliable than other patients, they miss appointments, they don't follow through, and that makes it harder to administer their care.
Dr Julian Raven:
It's true that many of them are sort of illogical, under the pressure of emotion and their disease.
Ted Williams:
D'ya'spose that basically a lot of them just aren't sick enough? Dr Goodheart seems to want to treat every little worry. I mean, I know they have their inner pain, it's bad, but it just doesn't hurt them as much as a heart attack or a broken hip. We may find it easier to work with a patient who is really over a barrel.
Buck Blazer:
I know we should be sorry for them, but don't you think some of them are just leakers? If they made up their minds to get well, I'll bet they could do a lot better.
Ted Williams:
I think we are getting a pretty good idea of what psychiatry does, now. It's been a pleasure, and I'll give you a call sometime.
Buck Blazer:
It's been a slice, Doc. (Dr Julian Raven leaves.)
Ted Williams:
I suppose we should have some AODA and mental health services, but they're just not too popular.
Buck Blazer:
There's no graphics for that stuff, no equipment, it looks like a lot of hot air. It's hard to sell. At least we don't have to worry about persuading those guys to work for us. The shrinks will run to sign up. Without us, they're history.

Scene V. (Dr Herb Wallner is praying at the south face of the Great Unknown.)
Dr Herb Wallner:
Eloi, eloi, sabacthani. Lord, forgive them, they know not what they do.

Scene VI. (Heaven. This is a small room with a high window. God is paring his nails and occasionally he looks out.)
God:
I took man and put him into Paradise, to dress it, and to keep it. I made the first HMO. They have eaten of the forbidden tree, the tree of knowledge of good and evil. I rained upon Sodom and Gomorrah brimstone and fire from out of Heaven, and I will destroy this city too. I will send a mighty asteroid.
The End.
–William Houghton, MD
Milwaukee[150th]

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Longitudinal study of semen quality in Wisconsin men over one decade

Frank M. Wittmaack, MD, and Sander S. Shapiro, MD, Madison

To determine whether there has been a time-related change in semen quality, we examined a Wisconsin population of men over a 10-year period. The semen quality of potential sperm donors was assessed between the years 1978 and 1987. The semen analyses included sperm concentration, motility, and morphology. No significant changes over time were observed for sperm concentration or motility. The percentage of morphologically abnormal sperm rose sharply between 1982 and 1983. This, however, coincided with a change in criteria used to identify abnormal sperm, and was, therefore, due to a procedural artifact. In summary, we found no evidence of a decline in semen quality in our Wisconsin population over a 10-year period. *Wis Med J.*1992;91(8):477-479.

Data from semen analysis provide the most important information in evaluating potential male fertility. There has been concern that the semen quality has been declining in industrialized countries over time. In 1974, Nelson and Bunge[1] presented evidence of deteriorating male fertility in terms of decreasing sperm concentration and an increase in abnormal morphology when they compared semen analyses of patients for elective vasectomy with men of known fertility from a study published 23 years earlier.[2] Several subsequent studies have also reported a decline in semen quality over time.[3-5,7,8] The validity of some of these studies has been questioned, because either the selection criteria used (eg infertile couples) did not provide a representative sample of the general population or the sample groups were not considered to be comparable.

We were interested in determining whether a more randomly selected, yet comparable group of men would show a declining trend in semen quality over time. Therefore, we investigated the sperm parameters of all potential sperm donors who made application to the semen donation program at the University of Wisconsin over one decade.

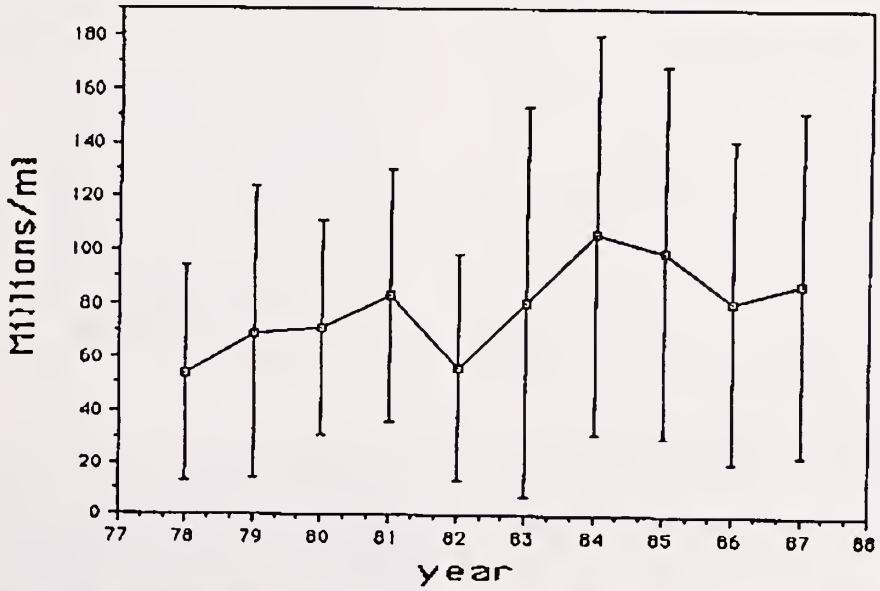

Fig 1.–Average sperm concentration of potential donors. Data shown represent the mean concentration in millions/mL ± standard deviation.

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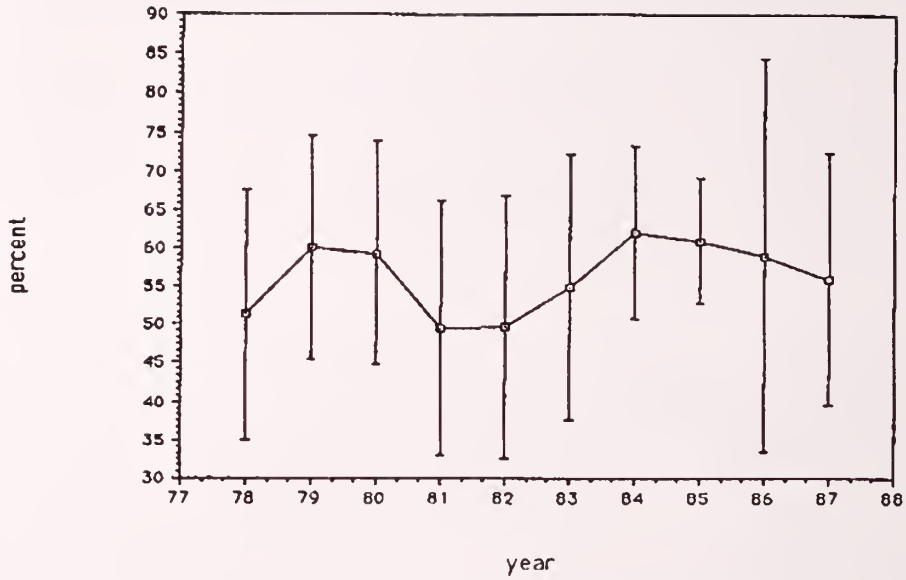

Fig 2.–Average sperm motility of potential donors. Data shown represent the mean percentage of motile sperm ± standard deviation.

Materials and methods

All potential donors were men who answered advertisements placed on the university campus. They had to have a college degree and be in good health, but they did not have to be married or of proven fertility to qualify for an initial semen evaluation. Subsequently, those with adequate semen quality underwent an extensive evaluation. They were accepted as donors, if all evaluable parameters met the minimal program requirements as described previously.[6] Semen samples were obtained at the Reproductive Endocrinology and Infertility clinic at the University of Wisconsin Hospital in Madison.

Data from our established donors served as an internal control for the data derived from the potential donor pool. If an established donor stayed in the program for more than a year, one semen analysis per year from that individual was entered into the data pool for this study.

Samples were collected via masturbation into sterile specimen containers following 72 hours of abstinence, and their analyses were begun within 30 minutes of collection. Analysis of an ejaculate included volume, sperm concentration, motility, and percentage of histologically abnormal forms. Statistical analysis was performed using the student's t-test.

Results

Average sperm concentrations of potential donors for the years 1978 through 1987 were determined (Figure 1). The mean concentrations varied between 55.6 millions/mL and 105.7 millions/mL. There was no statistically significant trend in sperm concentration over the decade of monitoring. Since ejaculate volumes were essentially stable over the study period (data not shown), no change in the average total sperm counts was found.

Average sperm motility ranged from 49.5% to 61.9% (Figure 2). Again, no significant changes were noted over time.

Figure 3 shows the percentage of abnormal sperm. A sharp rise was observed in the potential donor group between 1982 and 1983 ($p<0.001$). This, however, coincided with a change in criteria used to identify abnormal sperm. Therefore, the increase in percentage of abnormal forms between 1978 and 1987 is thought to be due to a procedural artifact. This is supported by a parallel increase in abnormal sperm morphology of our donor pool during the same years.

Discussion

A decline in semen quality over the past decades has been observed by various authors.[1,3-5,7,8] The effect, however, on different components of the semen analysis (ie concentration, motility, percentage of abnormal forms) has been variable in these studies.

Moreover, the validity of the first study by Nelson and Bunge[1] has been questioned, as potentially different study groups were compared.[9] They used data from men requesting a vasectomy, and compared them with data from men whose wives had just registered at a prenatal clinic.[2] The former group was probably older and had children less recently. Its fertility could not be assured. Neither group could be considered representative of the general population.

Several other studies used men undergoing infertility evaluation,[3,4,7,8] thereby increasing the likelihood that men with abnormally low semen quality would be included in the study population. Our study group, similar to that of Leto and Frensilli,[5] consisted of men interested in becoming sperm donors. Although they had to meet certain requirements (good health, college degree), these selection criteria seem unlikely to have influenced semen quality. We, therefore, feel that our study may be more representative of the general population than those mentioned above.

Another well known problem that influences interpretation of sperm data is the standardization of the semen analysis itself. Jequier and Ukombe reported a wide range of results in sperm concentration, motility, and abnormal morphology by laboratory technicians evaluating aliquots of the same sample of semen.[10] While an automated semen analyzer can provide consistent sperm counts,[11] the morphologic evaluation of spermatozoa remains a matter of personal subjectivity.[12]

The sharp rise in percentage of abnormal sperm in our study between 1982 and 1983 coincides with a change in the criteria used to identify abnormal sperm. The changes in the potential donor group are mirrored by the established donors.

We believe, therefore, that there was no true increase in abnormal sperm morphology in our study. This is supported by relatively stable data from 1978 to 1982 and again from 1983 to 1987.

Seasonal variation in human semen quality has been recently reviewed by Levine.[13] There seems little doubt that sperm concentration in non-equatorial regions is reduced during summer. Semen analyses of the potential donors in this study were randomly distributed throughout the year, thereby reducing the possibility that our data were biased by seasonal variability.

In studies reporting a decline in semen quality, environmental agents have been hypothesized to be the cause of the changes.[1,3,4,14] Although some spermatotoxins are well documented (eg radiation), the potential effect of others has remained controversial.[15,16] Our observations are in contradistinction to those studies. Whether these differences are due to the absence of a certain environmental agent in our area, the relatively low number of men and years in our study, or whether selection bias was responsible for the decline in semen quality in other studies cannot be stated with certainty. Continuing observation of large population groups is warranted in view of the significant implications that a change in semen quality would entail.

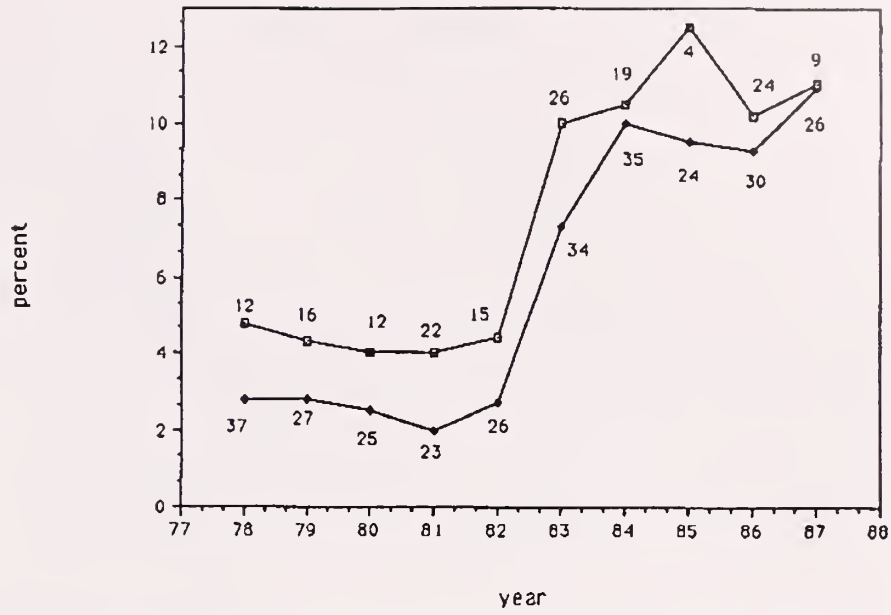

Fig 3.–Percentage of morphologically abnormal sperm. Upper curve potential donors, lower curve established donors. Numbers next to each point represent the number of men studied.

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Operation Desert Storm: clinical experiences at the 13th Evacuation Hospital, a Wisconsin National Guard unit

Yeu-Tsu Margaret Lee, MD; John D. Alvarez, MD; Janet A. Wilson, MD; and Lewis B. Harned, MD,
Honolulu, San Antonio, Wisconsin Rapids, and Madison

The 13th Evacuation Hospital, a National Guard unit, was deployed to the Persian Gulf Jan 11, 1991. We set up a 400-bed hospital and became fully functional 11 days before the ground war started. From Jan 11 to March 8, 1991, the hospital took care of 3,907 out-patients and admitted 435 patients. Approximately half the patients were admitted before the ground war began, while 88 of the 125 operations were performed after the ground war started. We admitted 61 patients for war-related injuries, and 28 required operations in our hospital. Since the ground war lasted only 100 hours, we took care of many more patients with non-war related injuries or illness. The various complaints and reasons for admission to the hospital are presented in detail. *Wis Med J*.1992;91(8):480-482.

Operation Desert Shield resulted in one of the largest, fastest mobilizations in military history. More than 500,000 Americans were sent to the Middle East after Iraq's Aug 2, 1990, invasion of Kuwait.

To provide medical care for anticipated war casualties, about 55,000 medical personnel were also deployed to the Persian Gulf (including 46,000 active duty persons and 9,000 National Guard and Reservist members).

The 13th Evacuation Hospital is a National Guard unit from Wisconsin, headquartered in Madison. The unit was activated for Operation Desert Shield in November 1990, and started pre-deployment training at Fort McCoy in Sparta, Wis.

During Operations Desert Shield and Desert Storm, the 13th Evacuation Hospital was one of the five evacuation hospitals of the 332 Medical Brigade, VII Army Corps. During the Gulf War, two hospital ships and 44 hospitals of various sizes were set up in that region. Each hospital had its own mission, objectives, and accomplishments.

As part of the after-action report, we have analyzed our clinical experiences, both for out-patients and for those who were admitted to the hospital. We believe this data should be published not just for the record, but also for the use of future military and medical strategic planning.

Background

On Jan 11, 1991, the 13th Evacuation Hospital left Wisconsin for Saudi Arabia. All personnel were billeted in Khobar Towers (near the Dhahran International Airport) until Jan 24, when the hospital moved to Northern Saudi by helicopters and truck convoy. A site about 50 km northwest of Hafr Al Baten and 1.5 km south of the Tapline Highway was chosen.

A 400-bed hospital was set up on the barren terrain, and sick calls were taken even before the hospital was ready. The Emergent Medical Treatment Tent (EMTT) was opened Feb 9 and closed March 7. The general medical and orthopedic clinics and patient wards were officially opened Feb 13 (11 days before the ground war started). The hospital discharged its last patient March 8 (23 days after its opening).

The hospital contained four intensive care units, eight intermediate care wards, and ten minimal care wards. The intensive care unit had 12 beds, and the other wards had 20 beds each. There were three operating rooms (each had two operating tables), one post-operative tent, and supporting services such as pharmacy, laboratory, radiology, central supply, etc.

There were 84 officers and 123 enlisted persons. Concerning direct patient

Table 1.–Various complaints of patients who were seen in the emergency medical tent.*

Non-war injuries (343 patients)
72 R/O fractures
45 lacerations
35 MVA accidents
34 eye injuries
25 burns
13 wind-related
12 head injuries
11 crush injuries
10 facial trauma
25 miscellaneous trauma
Various sickness (170 patients)
24 URIs
19 gastroenteritis
17 asthma, etc
11 gynecological problems
10 psychiatric
2 overdose
87 miscellaneous medical
Pain group (147 patients)
40 joint
38 chest
35 back
34 abdominal

* Sixty-one patients who had war-related injuries were excluded.

Dr Lee, Dr Alvarez, Dr Wilson and Dr Harned served with the 13th Evacuation Hospital during Operation Desert Storm. Dr Lee is with the Tripler Army Medical Center's department of surgery in Honolulu, Hawaii. Dr Alvarez is with the Brooke Army Medical Center's department of surgery at Fort Sam Houston in Houstoen, Texas. Dr Wilson practices at the Riverwood Clinic in Wisconsin Rapids. Dr Harned lives in Madison. Reprint request to: Dr Margaret Lee, Tripler Army Medical Center, Honolulu, HI 96818. Copyright 1992 by the State Medical Society of Wisconsin.

care, there were 55 nursing staff, 31 medical specialists, and 31 operating room technicians. There were 28 medical doctors and one oral/maxillofacial surgeon on the staff. Specifically, there were 11 physicians (with specialties in internal medicine, pediatrics, pulmonary, psychiatry and radiology) and 18 surgeons (with specialties in anesthesia, ENT, general and vascular surgery, gynecology, neurosurgery, oral surgery, orthopedics, thoracic surgery and urology). Although almost all of the doctors on the medical service were from the National Guard, all but three of the surgeons came from active duty army medical facilities.

Clinical experiences

From Jan 11 to March 8, 1991, the hospital took care of 3,907 out-patients and admitted 435 patients. Two hundred and twenty-four patients were admitted before the ground war began, and 211 afterward. Information on patients was obtained from daily log books kept by the admission office, the operating room, and the EMTT.

Among the 3,907 out-patients, 2,787 (71%) were seen for sick call, 721 (19%) were seen in EMTT, and 399 (10%) were seen in the orthopedic clinic. Among the 721 patients seen in EMTT, 61 (9%) had war-related injuries. The others had non-war injuries (43%), various illnesses (26%), and complaint of pain (22%). Table 1 gives a more detailed listing of the various complaints.

Among the 435 patients who were admitted, 61 (14%) had war injuries, 116 (27%) had orthopedic problems, 121 (28%) had other surgical diagnoses, and 137 (31%) had various medical conditions. Table 2 lists the reasons for admission for patients who did not have war injuries.

There were 125 operations performed, including 13 re-operations. Among the 28 procedures done for war-related injuries, 25 were performed on enemy prisoners of war. The most commonly performed procedures were orthopedic or general surgical types (about 45 procedures each, eight involved multiple specialties). Table 3 lists the 125 operative procedures. Among the 125 operations, 88 were performed after the ground war started. There were no anesthetic or surgical mortalities. When the patients conditions were stabilized, they were transferred via the medical evacuation system to other fixed facilities.

Table 2.–Reasons for admissions to the 13th Evacuation Hospital.*

121 Surgical admissions			
11	burns	11	urological
10	laceration	10	abdominal pain
7	head injury	8	R/O appendicitis
6	GSW	10	groin hernia
5	contusion	9	dental
3	MVA	7	gynecological
2	facial injury	6	tumor, cyst
11	other injury	5	rectal problems
116 Orthopedic admissions			
20	fractures	47	lower extremity
19	low back pain	19	knee
13	back injury	4	leg
17	upper extremity	13	ankle
	8 arm, 9 hand	11	foot
137 Medical admissions			
29	combat stress	7	neurological
5	suicidal	6	high blood pressure
17	athsma, bronchitis	6	pneumonia
15	chest pain	6	heat, dehydration
10	GI problems	6	arthritis, pain
7	sinusitis, URI	5	infections
7	allergy	11	others

* Sixty-one patients who had war-related injuries were excluded.

Table 3.–Types of operations performed at the 13th Evacuation Hospital.

125 Operations	
45	general surgery
46	ortho surgery
11	oral surgery
8	neuro surgery
6	gynecology
6	ENT
2	ophthamology
1	urology
45 General surgery operations:	
26	war injuries
11	soft tissues
4	colon, liver, vascular (2)
3	amputations
8	multiple (ENT, GU, NS, ortho - 5)
19	others
7	groin hernia
4	burn
4	appendectomy
4	abscess

Discussion

During Operation Desert Storm, there were two hospital ships and 44 hospitals in the Persian Gulf region. There were three types of hospitals: combat support hospitals, mobile army surgical hospitals, and evacuation hospitals. The 13th Evacuation Hospital was only one of five evacuation hospitals in the 332 Medical Brigade. We were located about 50 miles southwest of the western edge of Kuwait and south of the Iraq border.

The ground war lasted only 100 hours. One of the unique and lucky outcome of the Desert Storm Operation was that the total of American and allied wounded was much lower than what the commanders feared.

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Among the 3,907 out-patients we cared for, 2,787 were seen for sick calls, 721 were seen in EMTT, and 399 had orthopedic problems. There were only 61 patients with war-related injuries, which accounts for 9% of the patients seen at the EMTT and 14% of the patients who were admitted.

Among 435 patients admitted to the hospital with non-war related conditions, about a third had orthopedic problems, a third had other surgical diagnosis, and the remaining third had illnesses.

There were 125 operations performed on 112 patients: a third had orthopedic problems, a third had general surgical operations, and a third had operations by various other specialists.

We had almost all the medical and surgical specialties available at our hospital. Fortunately, we felt that our capabilities were not challenged.

Acknowledgement
The authors wish to thank the members of the 13th Evacuation Hospital who contributed greatly to the clinical work reported in this paper.

Editor's note: The opinions and conclusions expressed in this article represent those of the authors and are not those of the Department of Defense or the Department of the Army.[15014]

A spontaneous combined (heterotopic) pregnancy: a case report

Michael A. Schellpfeffer, MD, Kenosha

A spontaneous combined (heterotopic) pregnancy is presented. A review of the literature exemplifies the risk factors for the condition and a set of criteria for more reliable prospective diagnosis. A discussion of the uses and shortcomings of recent technologic advances in the diagnosis and treatment of the condition is then presented. *Wis Med J*.1992:91(8):482-484.

A COMBINED INTRAUTERINE and extrauterine (heterotopic) pregnancy continues to be a very unusual and fascinating entity. Certainly, this condition should be considered in the diagnosis and management of any patient with a suspected ectopic pregnancy or with a known twin gestation. Due to the relatively rare occurrence of this problem (an estimated 1 in 30,000 pregnancies) the diagnosis is often made retrospectively. Temporally, the diagnosis relates to the site of the extrauterine pregnancy with a Fallopian tube ectopic pregnancy presenting early and an abdominal pregnancy presenting late in the course of the gestation.

This case report is presented to illustrate the uses and the shortcomings of recent technologic advances in obstetrics and gynecology in the diagnosis and treatment of this enigmatic problem.

Reprint request to: Michael A. Schellpfeffer, MD, 1400 75th St, Kenosha, WI 53143. Copyright 1992 by the State Medical Society of Wisconsin.

Case report

P.P. was a 30-year-old woman, para 0-0-0-0, with a last menstrual period 6 weeks prior to admission, admitted with a 2-to 3-week history of lower abdominal cramping pain and a 1-week history of an intermittent pink discharge. Her menses were reported as regular, and she was having intercourse without contraception. She gave no history of associated gastrointestinal or urologic complaints, nor did she report any history of fever or chills. She did, however, report breast tenderness. Her medical history was unremarkable. Specifically, she gave no previous history of pelvic inflammatory disease or IUD use.

A physical examination revealed stable vital signs and a normal temperature. Her examination was unremarkable with the exception of her abdominal examination, which revealed generalized lower abdominal tenderness without rigidity or rebound tenderness. The pelvic examination revealed normal female external genitalia, a slight pink vaginal discharge with an otherwise normal cervix and vagina, and a slightly enlarged uterus with bilateral adnexal tenderness and no adnexal masses.

Laboratory studies demonstrated a positive pregnancy test and a hemoglobin and hematocrit of 12.5gm/dL/38.2%. A transabdominal pelvic sonogram was performed, which demonstrated a possible intrauterine gestational sac, although no fetal pole was seen (Figure 1). A 4 cm complex left adnexal mass was also noted (Figure 2).

Due to a suspected tubal ectopic pregnancy a laparoscopy was undertaken. A hemoperitoneum and an unruptured left ampullary ectopic pregnancy were discovered. Prior to the laparoscopy a dilation and curettage was performed to rule out a missed abortion. Grossly minimal tissue was obtained and pathologic examination of the tissue showed no evidence of chorionic villi. Subsequently, a pelvic laparotomy was performed and a linear salpingostomy performed to successfully remove the ectopic products of conception. Pathologic examination of this tissue confirmed the presence of

immature chorionic villi and decidua. At the time of surgery multiple filmy peritubal adhesions were discovered about the left Fallopian tube. The remainder of the pelvic cavity was grossly normal.

The patient's post-operative course was uneventful. On a routine post-operative visit 4 weeks after surgery, a physical examination demonstrated a persistently enlarged uterus. A serum HCG was obtained and returned positive. An ultrasound of the pelvis demonstrated a 12-week intrauterine pregnancy consistent with the patient's last menstrual period. Her subsequent prenatal course was unremarkable and she delivered spontaneously per vagina at 38 weeks gestation (by menstrual dates) a 5 lb 14 oz girl with Apgar scores of 9 and 9. The neonate's Dubowitz scores were consistent with a 38-week gestation and her neonatal course was uneventful.

Fig 1–A transabdominal ultrasound with a gestational sac and decidual ring (between cursors) suggestive of a very early intrauterine pregnancy or pseudogestational sac. Increased cul de sac echogenicity is also noted.

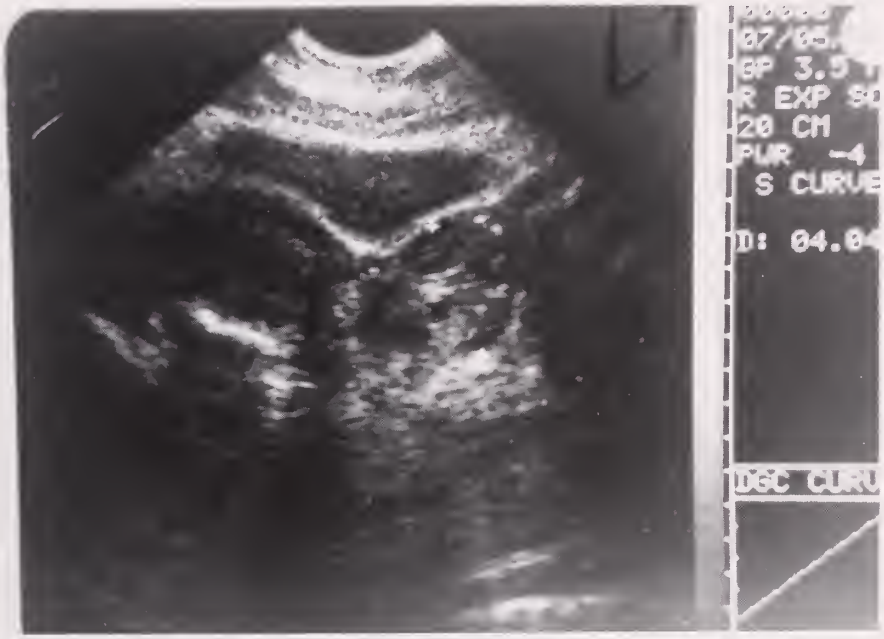

Fig 2–A transabdominal ultrasound with a 4 cm complex left adnexal mass (between cursors).

Discussion

The most comprehensive contemporary review of combined pregnancy was undertaken in 1983 by Reece et al.[1] In their review of the risk factors associated with combined pregnancies, two factors were clearly identified as significant: a history of pelvic inflammatory disease and the use of ovulation induction agents. They also established a set of criteria to allow a better clinical assessment of the possibility of a combined pregnancy. These criteria included: 1) a fundus compatible with dates in a patient believed to have an ectopic gestation; 2) two corpora lutea at laparotomy or laparoscopy and an enlarged, soft and globular uterus; 3) the absence of withdrawal bleeding and the presence of pregnancy symptoms following excision of an ectopic pregnancy; 4) hemoperitoneum following the termination of an intrauterine pregnancy; and 5) the combination of abdominal pain, adnexal mass with pain and tenderness, peritoneal irritation, and an enlarged uterus.

Felbo and Fenger, in 1966,[2] described the concept of an "early" and a "late" presentation of a combined pregnancy. The presentation was dependent on the location of the extrauterine pregnancy. An "early" presentation was associated largely with a Fallopian tube ectopic pregnancy, and a "late" presentation with an abdominal pregnancy.

This case report serves to reiterate the difficult in establishing an accurate prospective diagnosis of a combined pregnancy. Even with the advent of highly sensitive serum HCG and progesterone testing, as well as the refinement of ultrasound technology, the single most important factor in detecting this condition remains a high index of suspicion. This is especially true in light of the increased prevalence of pelvic inflammatory disease and the increased use of ovulation induction agents in advanced fertility

treatment (the two major risk factors for this condition).

This case also illustrates several points concerning the management of patients with a suspected tubal ectopic pregnancy. Many gynecologic surgeons have advocated the use of a routine prelaparoscopic/laparotomy dilation and curettage in the diagnostic evaluation of a patient with a suspected tubal ectopic pregnancy or a routine postoperative dilation and curettage as a prophylaxis against vaginal hemorrhage after treatment of an ectopic pregnancy. Certainly, if the patient desires to maintain a possible intrauterine pregnancy even in the face of vaginal bleeding a D&C should not be performed. This is especially true in the case of an infertility patient who has undergone fertility treatments involving the use of ovulation induction agents or advanced fertility treatment such as in vitro fertilization or gamete intra-fallopian tube transfer. With regard to routine postoperative dilation and curettage for prophylaxis against vaginal hemorrhage, there is little or no objective information documenting a significant incidence of heavy vaginal bleeding after treatment of an ectopic pregnancy. A more rational approach to the use of a D&C in managing an ectopic pregnancy might be its use when pregnancy is not desired as a diagnostic or therapeutic tool in the event of a negative laparoscopy.

Finally, this case exemplifies the limitations of the abdominal ultrasound in the diagnosis of an intrauterine gestation and the need for clinical correlation of patient history and physical findings with the ultrasound examination. Traditionally, the transabdominal pelvic ultrasound threshold for positive confirmation of an intrauterine pregnancy was 6- to 7-weeks gestation. With the recent introduction of transvaginal ultrasound this threshold has been decreased to 5- to 6-weeks gestation for positive documentation of an intrauterine pregnancy.

A well accepted concept in the area of transabdominal pelvic ultrasonography is the gestational psuedosac seen in association with a tubal ectopic pregnancy. This particular entity is a prime example of the ability of technology to mislead a clinician if a clinical correlation of the findings is not entertained. Certainly, with the advent of transvaginal ultrasound, as well as Doppler flow scanning, this diagnosis has decreased. These modalities, however, have still not altogether eliminated the confusion associated with an accurate prospective diagnosis of a tubal ectopic pregnancy.

In conclusion, this case report serves to illustrate yet another facet in the constellation of presenting signs and symptoms in this very unusual condition. It also raises questions concerning prior concepts employed in the diagnosis and treatment of an ectopic pregnancy especially in light of the increased incidence of this condition.

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1. Reece EA, et al. Combined intrauterine and extrauterine gestation: A review. *Am J Obstet Gynecol.*1983;146:323-330.
2. Felbo M, Fenger HJ. Combined extra- and intrauterine pregnancy carried to term. *Acta Obst Et Gynec Scand.*1966;45:140-155.

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Public health

Sheepskin rugs linked to crib death

Timothy J. Chybowski, MD, Madison

On Jan 17, 1992, 2-month old Rebecca Snell died in her sleep. Her father, John Snell, found her face down, her body cold and stiff, on her sheepskin rug. A registered nurse at Meriter Hospital, John immediately began cardio-pulmonary resuscitation and called to his wife, Barbara, to summon Med Flight. Life-saving measures were unsuccessful, and Rebecca Snell was pronounced dead at 2 am at University Hospital in Madison.

The death might have been attributed to Sudden Infant Death Syndrome (SIDS) had John not made an important observation when he lifted Rebecca's body off the sheepskin rug. He noticed the wool was wet with spit-up and stuck to her face; it peeled away only when he turned her body. The autopsy investigation included a study of that sheepskin rug. After numerous toxicological studies, Sunita Chandra, MD, and Jill Madsen, MD, determined the probable cause of death to be suffocation. In the autopsy report, they noted that "There have been reports stating the increased incidence of Sudden Infant Death Syndrome in areas such as New Zealand in which the children were found dead in a prone position with their faces buried in the bedding."

Just days after Rebecca's death, Enid Gilbert-Barness, MD, director of surgical and pediatric pathology at University Hospital and Lewis Barness, MD, professor of pediatrics at the UW School of Medicine, released a paper called "Cause of Death: SIDS or Something Else?" Dr Gilbert-Barness and Dr Barness emphasized in their paper that "up to half the deaths pathologists sign out as SIDS have identifiable–and often preventable–causes, ranging from hazardous sleeping conditions to undetected metabolic disorders."

Among the hazardous sleeping situations they cite is an infant placed prone on a sheepskin rug. "...(A)n infant's head can become buried in the rug's deep pile," they wrote. "The obstructive effect is magnified if the sheepskin is placed on a soft surface to form a hollow, or if the wool becomes wet."

The Snells received the rug as a baby shower gift. With it came an information sheet from the Madison retailer that sold the rug. The sheet told them the rug would provide "tactual stimulation" for their baby, which, it said, "...is very important for the baby's comfort and sense of well-being." It went on to recommend the face-down sleep position: "They like to nuzzle it, often face down, and will feel it with their fingers. Very soon, they associated it with sleep, mostly because they are comfortable on it and are comforted by it." Finally, it provided reassurance: "Do not be concerned that the baby might

Continued on next page

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suffocate ... air passes through the wool and the lambskin and the baby is able to breathe just fine." There are at least two retailers in Madison that sell this product, and many others statewide. In addition, several catalogs shipped nationwide promote the rugs with pictures of babies lying face-down on them.

In part because of the extensive marketing of this product, the Snells decided 6 weeks after Rebecca's death to go public with their story. On March 2, John and Barbara Snell and I held a press conference at Physicians Plus-Jackson to let the local media know what had transpired. That night and the next day, the media repeatedly told the story, warning parents to consider the evidence before putting their infants face-down on a slumber rug. The Associated Press wire service quickly picked up the story, and during the next week it appeared in most Wisconsin newspapers.

We had warned parents of the potential risks, but still felt as if we should be able to do more to remove this product from the market, or force manufacturers to include a warning on the package. Then the US Consumer Products Safety Commission called to say it had heard the Snell's story in Milwaukee and wanted to investigate. We sent the CPSC the *Contemporary Pediatrics* article by Dr Gilbert-Barness and Dr Barness, as well as a 1983 letter to the editor to a New Zealand medical journal. This letter may be the first published warning that sheepskin rugs might contribute to infant suffocation. Now, the CPCS has sent our information on to Washington, DC, where an investigation will be started to determine whether this product should be removed from the market or carry a warning sign.

On April 15, 1992, the American Academy of Pediatrics issued recommendations that "normal infants, when being put down for sleep be positioned on their back or side." The academy made this recommendation because studies from other countries demonstrate an association between infants being placed to sleep on their stomachs (ie, prone) with a higher risk of SIDS.

It may be that, because of the rug's deep pile, sleeping face down on a wool blanket poses an even greater risk. It is important to acknowledge that a single case report, such as this one, does not prove cause and effect. Nevertheless, given the information available to date, physicians should be aware of the potential risk. I believe that few parents would use these blankets if they were aware of this potential for harm.[150th]

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The *indicates members of the SMS.

March 1992

Abujamra, Fawzi N., Green Bay
* Behling, Ronald E., Madison
* Caya, James G., Burlington
* Chen, Hong Mo, Marshfield
* Cromer, Robert W., Antigo
* Effenhauser, Manfred
* Garvida, Cesar A., Manawa
* Hamilton, Gurcon H., Marshfield
* Han, Paul Zung-Ying, Wausau
* Jeffries, Donald A., Shawano
* Jessen, Kevin A., Tomah
* Johnstone, Michael F., Milwaukee
* Kaupie, Robert C., Wausau
* Klink, Bruce L., Milwaukee
* Kraegel, John H., Wauwatosa

Krause, Justin G., Wausau
* Kurtz, Jeffrey A., Schofield
* Laabs, John E., Neenah
* Larson, David L., Milwaukee

Laughlin, Kathleen M., Madison
* Lechmaier, Timothy E., Madison
* Lemon, Richard A., Middleton
* Lingen, Thomas A., Cumberland
* Lorenz, Frederick S., Burlington
* Matloub, Hani S., Milwaukee
* McDevitt, William P., Milwaukee
* McDonald, Donald H., Winneconne

Moede, Jesm G., Reedsburg

Newton, Carolyn G., Kenosha
* Nogler, Calvin D., Pound

Novak, Dorothy A., Hayward

Poley, Carl R., Green Bay
* Rose, Quentin F., Milwaukee
* Rosenthal, Barbara L., Montello

Rozario, Nirmala J., Milwaukee

Sammour, Mohammed A., Tomah
* Shack, James B., Racine

Smith, David R., Plymouth
* Starr, Robert A., Viroqua
* Woeste, David M., River Falls
* Wong, Walter, Racine[150th]

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SMS returns to Racine; board action reported

SMS BOARD MEMBERS returned to the city of Racine July 18, the site of the first meeting of the medical society, to commemorate the 150th anniversary of the State Medical Society. Racine Mayor N. Owen Davies welcomed physicians to his city with a brief message.

James Todd, MD, executive vice president for the AMA, addressed the SMS board at its meeting in Racine, congratulating Wisconsin physicians for reaching the 150th anniversary of the medical society and praising the SMS members for continuing to assume strong leadership roles within the AMA. The executive vice president also commended the medical society for initiatives taken to end domestic violence. Dr Todd also urged physicians to guard against civil war within medicine, saying that if physicians are to take an active role in health care reform, they must take care that their differences do not divide them.

Dr James Todd, executive director of the AMA, (r) marked the 150th anniversary of the SMS at a Board of Directors meeting. With him are, from the left: Thomas L. Adams, CAE, SMS executive vice president; N. Owen Davies, mayor of Racine; Pauline Jackson, MD, SMS president elect; Richard Ulmer, MD, SMS Board chair; and William Listwan, MD, SMS president. A Kenosha physician used the buggy (shown behind the group) to make house calls in the late 1890s.

"Every country with nationalized health care started by splitting the specialists and the generalists," Dr Todd said. "My concern is that we do not have in the medical profession the level of unity we need to move forward. Things on which we disagree have to be kept within the profession." If factions are split along specialty lines or state lines, pitting physician against physician, "you might as well go to work for the federal government because that's what the end result will be." The executive vice president said he believes long-term solutions to current problems with health care delivery and access will not come from the states, but that doesn't mean states shouldn't continue to pursue health care reforms. The experiments in Minnesota, Vermont, Oregon and other states may, however, influence the type of reform adopted at the federal level. "What ultimately happens at the federal level may be the result of a state or region demonstrating what is successful," he said.

Organized medicine is in a strong position right now to influence policy, according to Dr Todd. "We've never been in a better position in Washington to have an effect," he said, pointing to the 60,000 letters physicians sent to federal officials on CLIA and 100,000 letters sent out on RBRVS. "We didn't get all that we wanted but we got $10 billion at a time federal government was going bankrupt."

The executive vice president expressed optimism that the AMA would soon be successful in influencing changes in RBRVS to reinstate payments for electrocardiogram interpretation and eliminate reduced Medicare payments for new physicians. The AMA will continue to oppose multiple conversion factors such as the recent surgical update. Dr Todd said the multiple conversion factors will probably be in force for one year and then the scale will be changed back to its original form.

After addressing the medical society

board, Dr Todd remained in Racine to hear discussions and talked informally with board members at a small gathering held in observance of the SMS'150th anniversary.

The SMS board also heard reports from SMS President William J. Listwan; Auxiliary President Fe Abellera, SMS Chair Richard H. Ulmer, MD, Executive Vice President Thomas L. Adams, CAE, and Harry J. Zemel, MD, finance committee chair.

J D Kabler, MD, chair of the Interprofessional Code Committee, presented to the board for its approval a chapter on minor children to be included in the interprofessional code. After some debate on language, the SMS board voted to approve the chapter without amendment. The new chapter deals with consent for medical treatment; refusal of medical treatment and includes a section on abused or neglected children.

Patricia Stuff, MD, chair of the SMS delegation to the AMA, updated directors on the recent AMA annual meeting in Chicago while Kermit Newcomer, MD, presented information on the formation of a Medicare Part B Technical Advisory Committee.

In other business the board:

- approved recommendations from the Task Force on Quality Assessment and Practice Parameters that the SMS serve as a clearing house for dissemination of information on practice parameters; the SMS assume a leadership role in educating physicians about practice parameters and quality improvement and review; and the SMS monitor development of practice parameters, quality improvement and outcomes management; and

> "In my clinical experience" is a phrase that usually introduces a statement of rank, prejudice, or bias. The information that follow it cannot be checked, nor has it been subjected to any analysis other than some vague tally of the speaker's memory. (Crichton. *N Engl J Med.*1971;285:1491.)[150th]

- approved a request for creation of an ad hoc steering committee on mini-internships (the mini-internship pilot project is designed to increase understanding of medical issues by providing opportunities for legislators and other community leaders to experience firsthand a typical day in Wisconsin medicine).[150th]

SMS: Medical Assistance plan fails to improve access for OB services

The latest Wisconsin Medical Assistance Program's state plan amendment regarding access to obstetrical and pediatric services does not comply with the OBRA '89 requirement mandating that reimbursement rates for obstetrical and pediatric services be sufficient to assure the Medicaid population has the same access to these services as does the general population, according to Thomas L. Adams, CAE, executive vice president of the SMS.

Many physicians have stopped seeing Medicaid patients because levels of reimbursements do not meet expenses associated with patient treatment. In a letter to HCFA's regional administrator, Chester Stroyny, Adams said the increases included in the state's most recent State Plan Amendment submission (April 1, 1992) are "a step in the right direction," but "are not, in our opinion, sufficient to bring Wisconsin into compliance with OBRA '89."

The WMAP definition of participation--submitting one claim per year--is in conflict, Adams said, with the standard put forth in HCFA's draft guidelines calling for participation by at least 50% of relevant physicians and other health care providers, with "full participation" defined as "accepting all Medicaid patients who present themselves for care or treatment."

"The reality today in Wisconsin is that, while most physicians will see some Medicaid patients, more and more have been forced to limit the numbers of Medicaid patients seen as a result of insufficient reimbursement," Adams wrote. "The Medicaid patient who is turned away because the physician's practice cannot absorb further losses due to inadequate Medicaid reimbursement will find little comfort in the WMAP's conclusion that Medicaid patients have the same access to care as the general population." A copy of the SMS letter was sent to Gerald Whitburn, secretary of the state Department of Health and Social Services.[150th]

SMS to send fewer dues notices

To reduce postage and printing costs associated with multiple mailings, the SMS has cut down on the number of dues notices mailed each year to members. The first dues notice will be mailed in the latter part of August.

Members who wish to take advantage of discounts for early payment of their 1993 dues must pay by Oct 1, 1992. A final dues notice will be mailed to members at the end of the year. Watch your mail for your dues statement.[150th]

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Dodge County doctors accept the challenge

Anti-smoking campaign in grade schools is expanded in honor of the SMS' 150th

Shari Hamilton, assistant editor

"...I will never ever smoke in my entier life. Even if my best friend said she wouldn't be my friend if I didn't try it. My great grandfather died before I was born because of smoking. My great grandmother stopped after that. Your message was the best one I've ever heard. Aspechily the part about there was not a singale little thing good about smoking..."
–a letter written by a Beaver Dam third grader

In Wisconsin, more than 1 million children, adolescents and adults smoke cigarettes or use smokeless tobacco. Despite earlier declines, cigarette consumption in the Badger State has remained almost constant over the past 5 years. How do you convince the next generation to grow up to be nonsmokers, avoiding the hazards and injuries associated with tobacco use? It's a difficult question, but members of the Dodge County Medical Society believe there is a way to guide children away from the tobacco road. Since 1988, Dodge County physicians have gone into the elementary schools to talk with children, face-to-face, answer their questions and share information on tobacco. Recently, this vital program has been expanded in recognition of the 150th anniversary of the SMS, a celebration of caring for Wisconsin citizens.

The Dodge County Medical Society was the first Wisconsin county medical society to accept the challenge issued earlier this year by Richard H. Ulmer, MD, chair of the SMS Board of Directors. Dr Ulmer urged the county medical societies to celebrate the legacy of the SMS by making this a record year for charitable projects in conjunction with the medical society's sesquicentennial.

Accepting the challenge, Dodge County physicians chose to expand their "Smoke-Free Class of 2000 and Beyond" project by adding a DOC-ADOPT program and launching a poster contest for fourth grade students.

The "Smokefree Class of 2000 and Beyond" project is jointly sponsored at the national level by the American Cancer Society, the American Lung Association and the American Heart Association. The organizations embarked on the campaign in 1988 in response to then-Surgeon General C. Everett Koop's call for a smoke-free society by the year 2000. In Wisconsin alone, more than 35,000 students are expected to take part in the program.

Recognizing that each age group has different needs, the program features kits promoting age-appropriate teacher-led discussions for grades one through four. The packet for first graders, for example, contains: a teaching guide; a poster of the Smoke-Free Class of 2000; a form to order t-shirts and buttons; a master worksheet; a sample letter describing the goals of the program to parents; suggested activities for extended discussion; lyrics and music for the Smoke-Free Class of 2000 song; and five story cards to generate discussion.

After learning about the dangers of smoking, children are asked to make a commitment to refrain from smoking. Each student receives a certificate which he may sign to seal his promise to say "no" and walk away when offered cigarettes or tobacco.

Through DOC-ADOPT, the Dodge County Medical Society has insured this valuable tobacco education program will be carried through to the year 2000. Participating DOC-ADOPT physicians agree to adopt one or two schools in their county, accepting responsibility for encouraging students at these schools with an annual smoke-free message through the year 2000.

DOC-ADOPT physicians are given background materials on tobacco-related hazards, but each is free to develop his or her own message and format. Besides delivering smoke-free messages to elementary school students, DOC-ADOPT physicians also give out neon-colored pencils or other small gifts designed to keep the smoke-free message fresh in students' minds. Visiting physicians encourage classes to use the official Smoke-Free Class of 2000 materials to study smoking prevention in their schools.

Response from the children has been excellent, as their many letters attest. Students seem to remember the simple messages best: "...I liked when you said that you told Eric and Andy the only thing they should put in their mouth was a toothbrush and food," wrote one Dodge County third grader to her DOC-ADOPT physician. That same sentiment was repeated again and again, in variations, by her classmates. One student asked if the thank you letters could be displayed in the physician's office to let people know that children don't want to smoke.

"All of the doctors who have been involved have been very enthusiastic," said Michael Augustson, MD, one of the Dodge County program coordinators. "Both the doctors and the kids get a kick out of doing it."

Dr Augustson, who also serves as chair of the Dodge County Medical Society's tobacco control subcommittee, has gone to several area schools to speak on tobacco use. Through DOC-ADOPT, he is paired with Parkview School and Herman Consolidated School, both in Mayville. Other members of the Dodge County Medical Society Committee on Tobacco Control are: Lois Augustson; Dan and

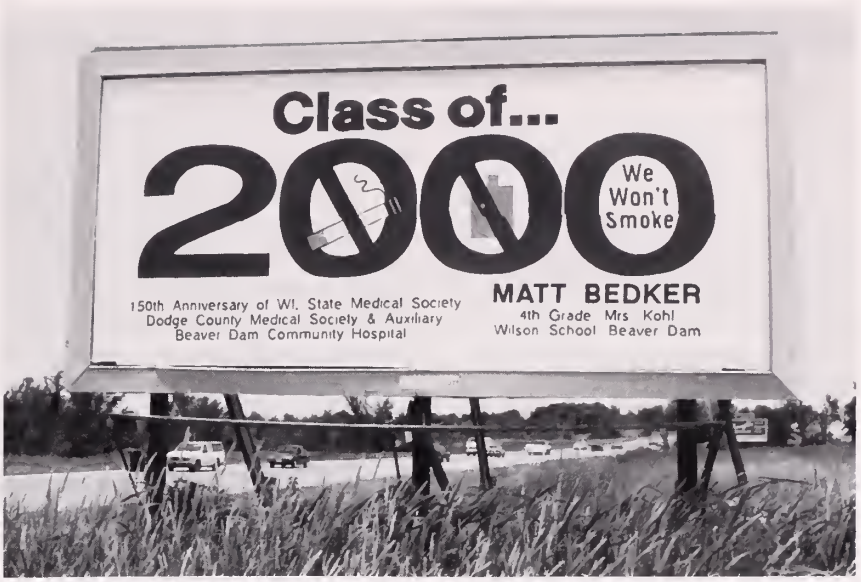
Denise Erickson; Craig and Cheryl Griebel; Cindy Hendrickson; and Tom and Sharon Kalinosky.

"The kids ask lots of questions and sometimes they turn out to be little smoking counselors," Dr Augustson reported. One student really got into the spirit of the program. He talked the cab driver who regularly drove him to school into kicking the smoking habit, Dr Augustson said.

This year in honor of the SMS' anniversary, the Dodge County Medical Society and its auxiliary sponsored a poster contest for fourth graders. The Dodge County Medical Society Auxiliary judged entries. Matt Bedker, a pupil at Beaver Dam's Wilson Elementary School, designed the winning poster, which was made into a full-size highway billboard. The sign proclaims, "Class of 2000–We won't smoke!" to motorists traveling on Highway 151 into Beaver Dam. Financial support for the project came from the county medical society and Beaver Dam Community Hospitals.

Ayaz M. Samadani, MD, the physician paired with Wilson School and an SMS director, said he has observed a change in the response level of students from the program's inception 3 years ago.

"The questions students ask now are much more advanced. They are very proud to raise their hands to show they are not smoking."



A billboard based on the anti-smoking poster design by a Beaver Dam fourth grade student. The billboard was sponsored by the Dodge County Medical Society, which has expanded its anti-tobacco campaign in area schools.

Because the physicians are going back each year to the schools, they are able to talk to students in greater detail about tobacco use. Dr Samadani said he spoke this year about second-hand smoke, a hazard many children were unaware they faced. Through the Dodge County program, Dr Samardani said many children are influencing their parents and other adults to rethink their tobacco habits.

To date, approximately 25 physicians have adopted the first through fourth-grade classes at 37 area schools, resulting in the involvement of nearly 4,000 students, according to Sharon L. Haase, MD, secretary of the Dodge County Medical Society.

Participating physicians are encouraged to organize a DOC-ADOPT team made up of office members, spouses and other auxiliary members, and physicians who are not matched with a school. Development of such a team actively involves others in the smoke-free movement and cuts down on the amount of work for the individual, Dr Augustson said.[150th]

Will you accept the challenge?

Richard H. Ulmer, MD, chair of the SMS Board of Directors, challenges you to help make 1992, the 150th anniversary of the SMS, a record year for charitable works by physicians. To accept the challenge, county medical societies are asked to describe their efforts to raise money for charitable causes or initiate outreach programs in their communities.

"The Dodge County DOC-ADOPT project is the kind of program we are pleased to see developed in conjunction with the State Medical Society's 150 anniversary," said Dr Ulmer, noting, "This program also has the potential for achieving a goal of the AMA in creating a smoke-free society by the year 2000."

To permit greater participation in the SMS sesquicentennial challenge, the deadline has now been extended to Sept 30. County medical societies participating in the challenge will be recognized in the *Wisconsin Medical Journal.* Any photographs or supporting materials may be displayed at the 1993 SMS annual meeting in La Crosse. Questions? Contact Shari Hamilton at 1-800-362-9080 or, in Madison, call 257-6781.[150th]

SMS task force looks at health care reform

The SMS Task Force on Health Care Reform, chaired by Kenneth M. Viste, Jr, MD, held its first meeting July 22. The Legislature adopted earlier this year numerous proposals from SMS' Operation Reform plan, developed in cooperation with hospitals and the business community, however, the debate on Wisconsin's future system has really just begun. The SMS task force is charged with developing a comprehensive plan for reforming Wisconsin's health care system to provide the basis for SMS' 1993-1994 legislative agenda.

At its first meeting, the task force reviewed health care reform efforts across the nation, focusing on states where comprehensive reform is in process. Initiatives were analyzed to determine who is covered, what services are covered, how costs are controlled, and how programs will be administered. The reform plans studied vary significantly. For example, Vermont's recent legislation commits the state to either a Canadian model or a German model following the development of specific plans for each by a new state agency and legislative adoption. Florida has adopted legislation to procedd with a single-payor or "play or pay" approach if employers fail to voluntarily cover employees by 1994.

Task force members are: John Beasley, MD, of Madison; Carl Getto, MD, of Madison; Duane Koons, MD, of Viroqua; Bradley Manning, MD, of Madison; Kathryn Nichol, MD, of Madison; John Petersen, MD, of Milwaukee; Robert Phillips, MD, of Marshfield; Marcia Richards, MD, of Milwaukee; John Scott, MD, of Madison; Robert Sellers, MD, of Superior; Kenneth Viste, Jr, MD, (chair) of Oshkosh; Roger von Heimburg, MD, of Green Bay; and Erik Gundersen (medical student representative) of Madison.[150th]

Domestic violence poster distribution begins, campaign gains exposure

The SMS campaign against domestic violence, spearheaded by SMS President William J. Listwan, MD, is continuing to gain momentum as well as attract media exposure. In the first few months of his presidency, Dr Listwan has addressed physician gatherings around the state; organized a task force of concerned physicians to study ways to address this threat to their patients' health and safety; and launched a poster campaign, encouraging patients to seek help from their doctors. Dr Listwan's efforts have begun to pay off.

The SMS has received numerous calls from physicians interested in joining the move to stop domestic violence. In addition, several media outlets have carried the SMS' message to the public, increasing opportunities for domestic violence victims to learn of the program.

The June issue of the *Wisconsin Medical Journal* contained a special section on domestic violence, including: an overview of Wisconsin statistics; discussion of the health issue by nationally recognized Wisconsin experts; and practical words from Dr Listwan on addressing domestic violence through medical practice. The first meeting of the Task Force on Domestic Violence is scheduled for Aug 28.

Physicians across the state will soon have copies of the SMS-produced poster on domestic violence. The poster, which features a background of news clips reporting actual incidents of violence in Wisconsin, encourages patients to discuss violence issues with physicians.

Members of the SMS Board of Directors received copies of the poster at the recent board meeting in Racine. Currently, SMS field staff are distributing posters as they meet with physicians across the state.

The anti-domestic violence posters will also be available at county medical society meetings in the fall. SMS Auxiliary President Fe Abellera, a member of the Task Force on Domestic Violence, has indicated the auxiliary will also take a strong role in the battle against domestic violence. As part of that effort, auxiliary members will be joining the SMS in distributing posters to physicians.

For those traveling through Madison, posters are also available at SMS headquarters, 330 East Lakeside St.[150th]

Family physician joins Task Force on Domestic Violence

A family physician from Monroe is the newest addition to the SMS Task Force on Domestic Violence, chaired by SMS President William J. Listwan, MD. Susan Kinast-Porter, MD, has accepted Dr Listwan's invitation to serve on the task force aimed at helping Wisconsin physicians address domestic violence through their practices. The task force, scheduled to meet Aug 28, will also discuss ways to increase identification, treatment and prevention of domestic violence.[150th]

Field of blood, field of the forgotten
The Potter's Field of Milwaukee County

Michael McBride, Milwaukee

A recent discovery of a forgotten pauper cemetery at the Milwaukee County Medical Center has profound and far-reaching ramifications. More than 5,000 are buried in this graveyard, compelling an investigation into the circumstances surrounding its loss. That the cemetery lies beneath county buildings without official knowledge is a disgrace. The proper dignity of a marked and undisturbed grave was denied to these former county residents because of their poverty. How this discovery is managed will reflect our commitment to both high ideals and the law. This project endeavors to reconstruct the origins of the pauper cemetery, containing a brief history of the poor in Milwaukee County, and an examination of the Almshouse, Milwaukee County's first medical institution. Finally, a postscript offers a parallel between the writings of Charles Dickens and the pauper cemetery. *Wis Med J.*1992;91(8):x-x.

In late fall of 1991, the *Milwaukee Sentinel* reported that a map outlining the boundaries of a 19th century pauper cemetery had been discovered at the Milwaukee Metropolitan Sewerage District Office. Close to 5,000 graves were estimated to be contained in this cemetery, which rested beneath the current Milwaukee County School of Nursing and an adjacent parking lot.[1] The magnitude of this find astonished me, raising many questions; who were these people, where did they come from, what circumstances led to their deaths, and how did their graves come to be forgotten?

The work toward creating a healthy climate for future generations begins now, and builds on the foundation of the past. The discovery of a massive pauper cemetery has profound implications for the community, and presents a wealth of potential for those serving in the field of public health and preventive medicine. If we fail to recognize and understand the issue at hand, pauper cemeteries will be our legacy to future generations.

The poor

"For ye have the poor always with you."–John 12:8

The term "potter's field" is often used interchangeably with pauper cemetery. The origin of the term "potter's field" can be found in the Old Testament book of Jeremiah, chapter 19. In the New Testament, Matthew makes reference to the potter's field in the death of Judas (Matthew 27:3-9):

When he found that Jesus had been condemned, then Judas, his betrayer, was filled with remorse and took the thirty pieces back to the chief priests and elders saying, "I have sinned. I have betrayed innocent blood." They replied, "What is that to us? That is your concern." And flinging down the silver pieces in the sanctuary he made off, and went and hanged himself. The chief priests picked up the silver pieces and said, "It is against the law to put this into the treasury; it is blood-money." So they discussed the matter and with it bought the potter's field as a graveyard for foreigners, and this is why the field is still called the Field of Blood.

To reconstruct the origins of the pauper cemetery, we must understand the history of Milwaukee's poor. The prevailing attitudes toward poverty in the mid-1800s were based on English Poor Laws. Soon after King Henry VIII served ties with the Roman Catholic Church, he abolished the monasteries. Until that time, the monasteries served as the main source of charity for England's poor. The attitude developed that poverty was caused by laziness with the poor seen as idlers and vagabonds. Thus, laws such as the Beggars Act of 1536 called for, "Suppression of mendicancy and vagabondage by infliction of severe and often cruel punishment."[2]

Shortly after Henry VIII died, his daughter Elizabeth, born of Anne Boleyn, became queen. Under her reign, the biblical quote, "For ye have the poor always with you" was used as an excuse to avoid assisting the poor. The impoverished lower class majority was viewed as the natural consequence of God's law.

The English Poor Laws were passed in 1601, effectively placing the care of the poor on local municipalities. It soon became common to confine the poor to debtor's prison, workhouses, and poorhouses. Those "inmates" who were able were forced to work the treadmill or spend long hours in the fields tending crops. This was seen as a legitimate means of reducing the cost of pauperism as well as instilling a work ethic in the poor.

The American colonies adopted the English Poor Laws, illustrated by the employment of indentured servitude as a means of working off debt and gaining freedom.

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McBride is a senior medical student at the Medical College of Wisconsin. Reprint requests to: Michael McBride, 1749 N 51st, Milwaukee, WI 53208. Copyright 1992 by the State Medical Society of Wisconsin.

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The Almshouse

"Over the hill to the poorhouse, I'm trudgin' my weary way."–Will Carlton

In 1852, Milwaukee County's Board of Supervisors purchased a farm for $6,000 to act as a poorhouse, and named it the Almshouse. Seven miles of difficult travel separated the Almshouse from the city, but the prevailing attitude was to confine the poor away from the general population. The distance also served to isolate those with infectious disease and the insane. Initially, the existing farmhouse received nearly everyone who was poor. The farmland was worked by the inmates and a cottage industry was formed.

Admission to the Almshouse required a judge's order, documented poverty, lack of any sympathetic relatives or friends, and the signatures of two county taxpayers.

In Milwaukee County, the annual report from the superintendent of the poor frequently listed causes for pauperism which included the elderly, the handicapped, alcoholics, the sick, and those labeled as "feeble minded." Immigrants were also more likely to end up at the Almshouse, with Germans, Irish, and Poles representing the greatest percentage.

Also recorded were the occupations of the inmates, with carpenters, housewives, and laborers documented most commonly.

Those responsible for balancing the budget were mindful of the goal of institutional self-sufficiency. For many years, the county took bids from private coffin-makers, and usually accepted the lowest bid, which in this case bought the inmates 4-foot caskets.[3]

Nineteenth century nomenclature reflected the attitudes of the time and were written into laws and public documents. The terms "vagrant" and "tramp" were used interchangeably, and defined as those males 16 years old or older, unemployed, who loitered, "... in outhouses, open air, groceries, drinking saloons, houses of ill-repute or of bad repute, railroad depots, fire engine houses..."[2] Female vagrancy was usually defined as prostitution. Statistics were kept by the superintendent on the number of tramps lodged per month at the Almshouse.

The economic depressions of the 1890s and the 1930s created a new attitude toward the poor. The reality that economic and environmental factors can cause poverty left the middle class insecure, thus shifting the formerly negative prevailing attitudes away. There was an evolving sensitivity toward the disadvantaged visible in the nomenclatural changes. Where Edmund Pottier referred to the needy as the "wretched of the Earth,"[4] Franklin Roosevelt called the poor "the forgotten man at the bottom of the economic pyramid."[4] In fact, Wisconsin officially removed the term "pauper" from statutes in the early 1940s.

Soon after the Almshouse's establishment, it became clear that the facility was not suitable for all the inmates it was intended to house. In 1858, the county opened a separate facility for children that included a school. The *Lady Elgin* steamship disaster of 1860, with more than 200 fatalities, resulted in a comparable number of orphans. Many of these children were sent to the Almshouse, creating a need for a larger facility which eventually developed into the Home for Dependent Children and Infants' Hospital in 1898 (Figure 2). Also in 1860, a hospital was established to separate and care for inmates with contagious diseases (Figure 3). Initially called the "Pesthouse," this institution evolved into County General Hospital and later into the present-day Milwaukee County Medical Complex.

In 1878, the Milwaukee County Insane Asylum was built (Figure 4), consisting of one facility for the chronically ill, called South Division, and another that cared for patients with acute illnesses, called North Division.

The medical staff of the Milwaukee County Hospital provided care at the Almshouse for the aged, the physically handicapped, the deformed, and chronically ill patients. The acutely ill were immediately transferred to the county hospital for treatment. Physicians on staff at the county hospital were regarded as the finest in the area. A dentist served the inmates once a week. A chief dietitian carefully managed the menu. Optical work, and artificial limbs were made and repaired for the poor.

The sprawling countryside's fertile soil offered plenty of opportunity for industry. During many years, the county farm and poorhouse reported profits from livestock and produce. The superintendent of the county farm listed an $18,000 profit in 1919. Inventory of that year included 30 horses, 550 swine, and 197 cattle, along with the income harvested from the fields of grain, rich pastures, stock, and pens.[5]

With time, the branching of medical facilities created a community of its own, complete with fire station, police force, butcher shop, power plant, bakery, and laundry. Many of the employees and superintendents resided on the grounds.

It is important to note that the Almshouse was not similar to debtor's prisons of Victorian England. Inmates were free to leave and did so once steady employment was obtained. The Almshouse was a reflection of the standard of care given to the poor. This care evolved and improved with the passage of time. A conscious effort was made to provide a comfortable atmosphere. This excerpt from a 1924 Milwaukee County Institutions brochure describes the various accommodations offered to the inmates: "The following facilities are provided for the comfort, entertainment, and use of inmates: Baseball games played on Institutions grounds; weekly movies; radio programs; entertainments by Societies and home-talent theatrical groups; books and Milwaukee daily newspapers; a smoking room for the men where they can smoke, play cards, checkers and other games; a parlors where music and games are furnished."[6]

Conditions at the Almshouse, however, were often criticized by the local press and reformers as overcrowded, inadequate, and often inhumane. The superintendent himself reported to the county board in 1888 that the condition

of the Almshouse was a "disgrace," stating, "Utter absence of proper ventilation, overcrowding to an extent which would horrify any sanitarian, no facilities for bathing, deficiency in water closets, no provision for cleansing persons and clothing inmates and tramps, and to crown all a 'foreign population' in addition to the native, far outnumbering it and hanging on with a persistency which defies all attempts to reduce its numbers or exterminate it altogether–a veritable colony and hotbed of vermin in addition to the above is the present Almshouse."[7]

The county board apparently listened and responded to the complaints, because newspaper articles reported that annual and periodic inspections by medical personal, charitable institutions, and the board ensured.

The inmates of the Almshouse, besides working the fields and tending livestock raised carp in several of the county ponds to sell at the local market. They also participated in the manufacture of textile and wood products. One such product crafted by the poor were coffins, which were undoubtedly destined for the use of those unfortunates who died while residing at the Almshouse.[6]

In the event that an inmate died, the 1894 edition of the *Milwaukee County Rules and Regulations* lists the responsibilities of the superintendent of the Almshouse. Rule 17 states: "The Superintendent shall keep a record of all pauper burials on the County Farm, file all burial permits, and place a painted and numbered head board at each grave, which grave shall, in no case, be less than six feet deep. The burial record shall specify the name of the deceased, date and cause of death, number of burial permit, and the number of the grave in which buried. It shall be the duty of the Superintendent to see that the cemetery is kept in decent order."[8]

The superintendent for the poor was often delinquent in the care of the cemeteries. A *Milwaukee Sentinal* newspaper story in 1878 titled, "A Disgraceful Potter's Field," complained of coffins popping out of the swampland following heavy spring rains since only eighteen inches of earth covered the coffin lids.[9]

The register of burial at the Milwaukee County Poor Farm documented burials beginning in 1882, with the last entry listed in 1974. A review of the record lists approximately 8,200 burials total. Most were from the Almshouse, county hospital, or transported from area hospitals and downtown morgue. Four hundred and thirty-one persons were entered as "unknown," with a surprising number of infants and children documented. The individual age was not recorded until 1898, and cause of death was registered only beginning

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in 1908.[10]

Causes of death are a reflection of 19th century medical nomenclature, including marasmus (infant lack of calories), apoplexy (stroke), inanition (adult malnutrition), typhoid, tuberculosis, morphinism (addiction to morphine), and delirium tremens (severe alcohol withdrawal). Other causes were the Spanish Influenza epidemic of 1918, and periodic outbreaks of smallpox, and cholera. The economic depressions of the 1890s and the 1930s were evident in the high number of suicides, homicides, and deaths due to alcoholism. Drowning deaths and railroad accidents were the most frequent trauma related deaths reported.[10]

In the 1880s, two proposed name changes for the Almshouse reflected the insensitivity of that time period: County Farm for Inebriates and Idiots (1883) and the Milwaukee County Retreat for Weak and Feeble Minded Persons (1885).[11] In 1917, the name was officially changed to the County Infirmary. The infirmary was torn down in the mid-1970s and replaced with a parking lot. The residents, staff, and overall operation of the infirmary were transferred to the former tuberculosis sanitarium, Muirdale, now know as Rehab West, functioning as a care facility for the elderly with mental illnesses. This facility was slated for destruction in June 1992.

Archaeology

"Just one last favor I'll ask of you. See that my grave is kept clean." –Bob Dylan

According to Public Law 89-665; 91-54, 95-422, and 94-458, the National Historic Preservation Act, an assessment of the archaeological potential of a location must be made before any disturbance of the premises for construction takes place. The Great Lakes Archaeological Research Center of Milwaukee is involved in the study and excavation of the Potter's Field and has reported on past reconnaissance work on the county grounds. In 1980, this firm investigated five proposed diversion structures planned by the Milwaukee Metropolitan Sewerage Commission.

Its conclusion was that construction activities for the 84th Street and Wisconsin Avenue diversion structure would disturb a middle- to late-19th century pauper cemetery. Furthermore, a pipeline construction project in 1971 encountered burials just north of Wisconsin Avenue west of the 8500 block.[12]

Its findings also include a *Milwaukee Leader* newspaper article from 1932 that reported the discovery of coffins during the construction of the current nursing residence. "The nurses residence is on the site almost in the center of the 15 acre field which was set aside 70 years ago for the graves of the penniless and unknown."[12]

After tabulating the number of recorded burials in the register between 1882 and 1929, and factoring in the number of unknown burials from 1852 to 1882, well over 5,000 people may be buried in this original pauper cemetery. The archaeological report concluded that, "...further investigations, eg, test excavations, should be conducted to determine the presence or absence of burials in the construction impact zone."

A total of four pauper cemeteries have been located (Figure 4). The most recent burials were placed in No. 3, known today as the Milwaukee County Cemetery. One manager of the county grounds stated that the poor were buried three deep at this site. Northwest from this cemetery lies a cast-iron headstone bearing the inscription "No. 89" which identifies cemetery No. 2. Potter Road, which intersects with Mayfair Road, is a vestigial reminder of the cemeteries.

The cemetery currently under excavation covers an estimated five acres. The graves were buried in an organized plan, with the head of the coffins facing west. At this time, more than 310 burials have been removed. Most of the pine coffins have decayed, preventing a complete preservation of the bodies. The poor were buried naked without any personal items enclosed. Many coffins contained two bodies, and a surprising number of skeletons have been found with severed legs or missing lower limbs. The explanation could lie in the decision to purchase coffins less than 4 feet long, necessitating amputation at the time of burial. Autopsies were performed on many. Only a handful of metallic tags, inscribed with numbers, indicate identity. A coin purse was located in one burial with what appears to be 2-cent pieces corroded together. What is believed to be a plastic comb was found in one grave.[13]

Excavation was to continue through December 1991 and resume in the spring of 1992. The time-consuming and often tedious process of removal of the bodies is costly and has been hampered by inclement weather. An average of 10 hours is invested in the removal of a single body. The remains are placed in cardboard boxes, catalogued, and stored in the basement of the Great Lakes Archaeological Research Center. Volunteer forensic pathologists are currently involved in the analysis of each specimen. A full report may not be completed until late 1993.

Ethics

"Show me the manner in which a nation cares for its dead, and I will measure with mathematical exactness the tender mercies of its people, their respect for the laws of the land and their loyalty to high ideals." –William Gladstone

The last official burial in the original pauper cemetery occurred in 1929. Three years later, in April 1932, graves were discovered during construction of a nurses' home. A *Milwaukee Journal* front page article on April reported the discovery, describing the fate of many burials at this site.

"Discolored water poured from the black wood coffins as they were lifted from the ground. The rotted pine of the boxes collapsed in the bucket of the power shovel. Splintered wood and decayed bones were strewn alike as the boom swung to empty the bucket into trucks.

"The debris was hauled a few hundred feet west of the nurses' home, spread near the hospital for the chronic insane and crushed into the ground as the basis for a proposed landscape project.

"...The proposed site was leveled and the whole potter's field graded and seeded.

"About 200 graves were transferred at the time to a new potter's field–now called the County Cemetery ... Most of the graves removed to the new cemetery were those which had been given some attention by relatives of the deceased. Many of them had markers or small monuments."[14]

Not only were the graves of more than 5,000 persons forgotten, but when burials were discovered it appears the treatment of the remains was callous and undignified. County authorities neglected the cemetery. With knowledge of the cemetery's presence, county authorities approved the construction of the nurses home, permitting the aforementioned hideous disinternment.

Coincidentally, the headlines from the April 6, 1932, *Milwaukee Journal* refer to William Coffey, the superintendent of County Institution, who was largely responsible for the historical foundations of the Milwaukee County Medical Complex. He began his reign on the Board of Administrators in 1915 and continued to serve the county until his retirement in 1952. Steven Avella, a contributing author of the book *Trading Post to Metropolis,*[15] describes Coffey as an administrative genius with skills and dedication that guided the course of Milwaukee County history in the development of the Medical Center. He states, "Coffey's tenure of over thirty years was characterized by a consistent stress on administrative consolidation and the expansion of services to the needs," and, "his longevity had assured the necessary stability to plan and execute a long-range vision."

In the 1932 *Milwaukee Journal* story, Coffey responds to a delegation of public welfare officials from the Twin Cities, who were assessing Milwaukee County's plan for assisting the poor. The "Milwaukee plan" was a nationally regarded success as a model for poor relief adopted by many large communities to cope with the tragic depression of the 1930s. In February 1932, Milwaukee assisted more than 27,000 families with poor relief. While other communities across the country were ravaged by the depression, Milwaukee's poor were well cared for, largely due to the vision of Dr Coffey.

It is possible that the stock market crash of 1929 and subsequent depression forced Coffey to triage decisions based on economic priority. The financial cost to exhume and rebury the graves of Potter's Field would have been impractical at that time. Since Dr Coffey displayed great sensitivity to the poor, it seems uncharacteristic that a massive cemetery would be forgotten.

More recently, a front page article of the *New York Times* reported the discovery of an 18th century potter's field in New York City. Excavation has delayed construction at the cost of $6 million.[16] Thus, Milwaukee County is not the only

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AMERICAN MEDICAL WRITERS ASSOCIATION

Continued from preceding page
community faced with the management of a pauper cemetery, and how the graves of Milwaukee's Potter's Field are treated has important ethical ramifications for communities facing similar dilemmas.

If we believe in what Gladstone wrote, and aspire to become a society remembered for equality and respect for human dignity, than we are compelled to act and right this wrong. Because those buried and forgotten were poor, it is crucial to respond in a manner symbolic of our egalitarian ideals. It has been said that a society will be judged by the way it treats its poor. From most accounts, the poor in Milwaukee County were treated with dignity and respect, while still living. From Rule 17 a legal commitment was made to continue care even after death.

The poor may always be with us. Milwaukee County struggles today with an increasing number of homeless, unemployed, indigent, and needy people. In June 1991, a Milwaukee opinion survey on the reasons for poverty and homelessness found that attitudes toward the poor depended on whether respondents knew someone who was impoverished.

Repairers of the Breach, a Milwaukee newspaper for and about the poor, reported that drug and alcohol abuse and lack of a strong work ethic were reasons given for poverty by those people who lacked knowledge and contact with the poor. In contrast, those who provide services to the homeless and poor cited lack of affordable housing, lack of adequate paying jobs, dependency, and mental health problems as causes for poverty.[17] The former attitude is not unlike that held by the creators of debtor's prisons and poor laws.

Today, there is no need for a potter's field or pauper cemetery. If someone dies in Milwaukee County without financial means to pay for burial, the county has contracted with local private cemeteries to assist with cost and arrangements. Milwaukee County authorized 637 funerals for the indigent in 1990.[20]

The future

"Pave over paradise and put up a parking lot." -Joni Mitchell

The manner in which the pauper cemetery is handled will reflect on our community and our society. Immediate cremation of the remains would save the county further costs and construction could then proceed. Curation for research and study would perhaps satisfy the archaeologist, pathologist, and others committed to the advancement of science. The Potter's Field discovery, however, represents 5,000 human beings, former residents of this county, who were neglected and forgotten because of their poverty. The elderly, the sick, the orphaned, the handicapped, and immigrants were buried in that cemetery. They do not deserve to be treated as museum pieces.

Science should be allowed to glean what it can from these remains, but without losing sight of fundamental humanitarian ideals. Following a reasonable period of curation and study, the remains should be reburied at the site of the present Milwaukee County Cemetery with a modest symbol to act as a memorial. Perhaps, this effort will help set a precedent for the future management of discovered cemeteries.

Postscript

"I will live in the past, the present, and the future." – Ebenezer Scrooge

At the age of 12, Charles Dickens was forced to work in a boot blacking factory to help pay his father's way out of a debtor's prison. The experience had a profound and lasting effect on Dickens and his writings reformed western society. The public health movement found its origin in the imagination of Charles Dickens. Through writings on sanitation, occupational health, and the treatment of the disadvantaged, Dickens helped to change and improve the course of history.

A few years after Dickens published *A Christmas Carol*, in 1843, Milwaukee County established the Almshouse. The story's theme is the prevailing attitudes of society toward the poor. Dickens describes a lonely, greedy, and uncaring man who refuses to give charity to London's poor, and instead points to the prisons, workhouses, and poor laws as his contribution to the impoverished. Scrooge is visited by three ghosts. The last, The Ghost of Christmas Future, takes him to a cemetery containing his own tombstone. Like Judas, Scrooge is filled with remorse, crying.

"Men's courses will foreshadow certain ends, to which, if persevered in, they must lead,' said Scrooge. "But if the courses be departed from, the ends will change. Say it is thus with what you show me!"

Seeing the past, the present, and the future converted Scrooge, changing his attitude toward the poor, toward family, toward life. Upon waking up and realizing it was all a dream, Scrooge found he had a second chance. "I will live in the past, the present, and the future," Scrooge proclaimed. He made large financial contributions to those collecting for the poor. He re-established his family relationships. Most importantly, Scrooge helped the impoverished Cratchit family, and to the sick Tiny Tim he became, in Dickens' words, "a second father."

Dickens' challenges all to wake up and change the course of history. By returning dignity and respect to the thousands buried in Milwaukee County's neglected and forgotten pauper cemetery, it is possible to depart from the current course. By resolving to live in the past, the present, and the future, society can make a commitment to high ideals as did Scrooge. By fostering a compassionate attitude toward the poor, society can be more confident when the future passes its ultimate judgment.

Addendum

My great, great grandfather, Peter McBride, immigrated to Milwaukee the same year the Almshouse was established in

1852. He was 7 years old, poor, and one of more than 4 million Irish who left Ireland because of English oppression and the devastating Potato Famine. My grandfather, George McBride, was sent to work at Milwaukee County's Almshouse as a teenager. His father wanted the boy to see the effects of poverty and develop a strong work ethic. I am a Milwaukee County resident and medical student, and aspire to train at the medical center and eventually practice medicine in the Milwaukee area.

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A glimpse into our past

Richard D. Sautter, MD, medical editor

40 years ago

Demands for health care. The three most common complaints concerning medical practice of the day were: "inability to get doctors to make house calls, long waiting periods in the doctor's office, and scarcity of physicians in small communities." The SMS president accused "government propaganda" of creating a public impression of a physician shortage and creating "dissatisfaction with medical service." He wrote, however, that "If we are to win the fight to preserve private medical practice, we must satisfy the needs of the public."

This sounds familiar. Favoring a plan for national health insurance, President Truman formed his Commission on the Health Needs of the Nation (to which Wisconsin's Gunnar Gundersen, MD, was appointed, and from which Dr Gundersen immediately resigned). The AMA called it a "stacked" commission, "palpably political in its design." Meanwhile, Gov Warren entered the presidential arena favoring a national system of "prepaid medical care," and the AFL joined with the CIO in an attempt to line up smaller unions behind a campaign for "national compulsory health insurance."

The cold war in deep freeze. The *WMJ*, like the rest of the nation, was concerned about war with the former Soviet Union, publishing a number of civil defense articles with titles such as "Medical Aspects of Atomic War" and "Defense Against Biologic Agents Employed in Warfare." The *WMJ* also offered six "survival secrets for atomic attacks" and encouraged physicians to share them with their patients: 1) Try to get shielded (eg, if outdoors, jump in a ditch); 2) Drop to the floor or ground; 3) Bury your face in your arms; 4) Don't rush outside right after a bombing–the advice was to wait a "few minutes" for an "air burst" and "1 hour" for a "other bursts" to give the radiation a "chance to die down"; 5) Don't take chances with food or water in open containers; and 6) Don't start rumors–"In the confusion that follows a bombing, a single rumor might touch off a panic that could cost your life."

80 years ago

From a distance, the connection isn't clear. Dr Horace Brown, of Milwaukee, collected statistics from his fellow physicians to support his complaints about telephone rates and service. The completed report was submitted to the Milwaukee County Medical Society, the president of which then

Continued on next page

appointed a committee to present the report to the State Railroad Commission. And we thought our bureaucracies were confusing.

An early reformer. Dr Ralph Elmergreen, of Milwaukee, was writing in the *WMJ* of surgical treatment of vaginal ptosis when he noted that medical science was not always applied equally between the genders: "To those of us that have spent some time in the dissection of the female perineum, the textbooks on anatomy offer but little comfort. We look in vain toward Gray, Holden, or even Piersol, for a full and correct description of the structures and anatomic architecture of the female perineum. Thus Gray fills several pages in describing the male bladder, but he dismisses the female bladder with one short paragraph."

Taking stock of human stock. A Madison physician delivered a paper at the SMS annual meeting, and later had it published in the *WMJ*, in which he decried the weakness of the public will to apply the "science of eugenics" to "build up a vigorous enlightened citizenship." He wrote that the "essentials of proper mating" were "health and beauty and vitality, moral worth and mental integrity," and that he favored the forced sterilization of the insane, epileptics, and "drunkards," but complained that such legal action did not reach to alcoholics, "'street walkers' who pass for respectable women," petty thieves, imbeciles, or paranoiacs. He blamed public sentiment for "the absurd fetish of 'personal liberty' for the fact "that the eugenics of horses, hogs, and chickens" were taught in universities "while the eugenics of man is passed over..." Not too much later, across the Atlantic, we saw the handiwork of those who would build a master race.

120 years ago

The mystery of medicine. In an effort to explore environmental factors in disease prevalence, the SMS formed a committee, the members of which were to "collect all the facts attainable in his region, respecting the general conformation of the country, the character of the soil, and of the water, the amount of rainfall, with notes of Barometrical and Thermometrical observations, Electrical Phenomena, and prevailing diseases ... to which his district has been most subject." The diseases and methods of exploration may have changed, but the search-and the mystery-continues today.

The frustration of medicine. The mystery of medicine caused a great deal of frustration for the physicians of the time: they understood that they knew little of what caused disease; they were unable to find the cures they so desperately wanted to provide; and they were frustrated at how slowly their art was becoming a science. Consider the remarks of SMS President H.P. Strong, MD, of 1871: "Our ancestors, our fathers, knew a great deal. Do we know positively a great deal more? Much of what is styled progress is nothing but gyration, resembling the progress of the dog that follows its own tail. It is questionable whether we treat diseases so very much better than did Boerhaave and Sydenham, as we sometimes imagine. Medicine is slowly advancing, and will probably yet arrive at that state when it may with propriety be considered science.... Men, learned in all things else, are fools in medicine."

Medical non-education. In 1871, medical students in Italy studies 6 years, in Germany 5 years, in France 4 years, in the United States 12 to 15 weeks. Dr O.W. Wight, of Oconomowoc, wrote "Moreover, the preliminary study, the necessary preparation, is (in these other countries) nearly equivalent to graduation at an American college. With us, no preparation is required. Any ignoramus can begin the study of the great healing art. Only two courses of lectures, varying in length from twelve to fifteen weeks, are demanded of the candidate for professional honors.... With such slender and precarious preparation a young man can be admitted to one of the most responsible stations in life." Dr Wight described the American physician's apprenticeship as 3 years of currying the doctor's horse, splitting the doctor's wood, collecting the doctor's bills, and even babysitting for the doctor's wife. "The whole system," he wrote, "is vicious." Little wonder then, that the science of American medicine progressed so slowly.[15th]

WISPAC to interview political candidates

The WISPAC Board of Directors met July 29 to welcome new board members and continue discussing endorsements for the 1992 general election. Announcement of new board members is pending approval by the SMS Board of Directors.

Over the course of the next two months, WISPAC members will be interviewing candidates for open legislative seats to learn more about their positions on health care issues. This year, in addition to the usual open seats, several vacancies have resulted from legislative redistricting. WISPAC members intend to complete interviews and make endorsement recommendations by the end of August.

During this election year, physicians are strongly encouraged to become more active in the political arena. For information on WISPAC, call Mike Kirby at 1-800-362-9080 or in Madison (608) 257-6781.[15th]

Physician briefs

Andrew Baertsch, MD, has opened a practice, Northland Center for Plastic and Reconstructive Surgery, in Superior. The Hayward native received his medical degree from the University of Wisconsin, where he completed residencies in surgery and plastic surgery.

Wanda Lavendel Bincer, MD,* has joined the staff of Affiliated Counseling Services in Beaver Dam. Dr Bincer has been in private practice in Madison since 1972. She is a trustee of the Parents of Murdered Children national board and a member of the Wisconsin Crime Victims Council. She was the recipient of the Community Service Award by the American Medical Women's Association.

Eric Eisenberg, MD, of Beloit, recently became board certified in gastroenterology after passing an examination given by the American Board of Internal Medicine. Dr Eisenberg has been board-certified in internal medicine since 1986.

Beth Gillis, MD, formerly a solo family physician at the Tigerton Clinic in Shawano County, has joined the Shawano Clinic. Dr Gillis is a board-certified family physician.

Mark Hennick, MD, and **Timothy Ablett, MD,** have joined The Doctor's Office, a primary care service of Marshfield Clinic, in Pittsville. Dr Hennick, an internist, graduated from the Medical College of Wisconsin and completed a residency at St Joseph's Hospital in Marshfield. Dr Ablett, also an internist, is a 1971 graduate of the Harvard Medical School.

Walter Hogan, MD, professor of medicine at the Medical College of Wisconsin and co-chief in gastroenterology at Froedtert Memorial Lutheran Hospital, has become president of the American Gastroenterology Association.

Mark Kaminski, MD, has joined the staff of Riverview Hospital in Wisconsin Rapids. An emergency room physician, Dr Kaminski earned his medical degree from Bialystok (Poland) Medical School in 1974. Prior to relocating to Wisconsin Rapids, he practiced in Lakeland Medical Center, Elkhorn.

Richard D. Larson, MD, is the newest addition to Mercy Center for Family Medicine in Janesville. Dr Larson will also serve as director of the Southern Wisconsin Family Practice Residency Program. He has been in family practice in Fort Atkinson for the past 19 years. He earned his medical degree from the University of Wisconsin Medical School.

Lily Liu, MD, a family physician and geriatrician, has joined Group Health Cooperative of Eau Claire. Dr Liu completed her family practice residency at Sinai Samaritan Medical Center in Milwaukee. She completed a geriatric fellowship program in 1990 at the University of Wisconsin and Veterans Administration hospitals in Madison.

Julianne R. Newcomer, MD, has been appointed assistant professor of obstetrics and gynecology at the Medical College of Wisconsin. Dr Newcomer practices at the Milwaukee County Medical Complex and Froedtert Memorial Lutheran Hospital. She is a 1987 graduate of MCW, where she won the Hofmeister Award for outstanding achievement in obstetrics and gynecology. She completed a residency at MCW-affiliated hospitals.

John E. Nilles, MD, of Mishicot, will retire from active practice in September. Dr Nilles, a general practitioner who earned his medical degree at Marquette University's medical school, began his career in Mishicot in 1952. Dr Nilles currently serves as medical director for Hamilton Memorial Home in Two Rivers.

Mary Pat McManmon, MD, and **Paul MacMillan, MD,** are the newest members of the River Falls Medical Clinic. A 1989 graduate of the St Louis University Medi-

Continued on page 503

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Area of interest within Family Violence: ☐ Child Abuse ☐ Sexual Assault ☐ Domestic Violence ☐ Elder Abuse ☐ Other

American Medical Association

Physicians dedicated to the health of America

Continued from page 501
cal School, Dr McManmon has recently completed a University of Wyoming family practice residency program in Casper, Wyo. Dr MacMillan recently completed a 3-year residency program in family practice at the Mid-Michigan Regional Medical Center in Midland, Mich.

Robert Pfeffer, MD, was recently honored by the Port Washington-Saukville school board for his 15 years of service as the school district's medical advisor. Dr Pfeffer moved from the school district to Ripon last year.

Donene A. Rowe, MD, will join Watertown Family Practice Association, SC, in September. A 1989 graduate of the University of Wisconsin Medical School and Oconomowoc native, Dr Rowe served a residency at St Mary's Hospital in Madison. She is a former emergency room physician at Rural Wisconsin Hospital Cooperative and assistant professor of anatomy at Colorado State University in Fort Collins, Colo.

Mark Siegel, MD, has accepted the position of medical director for Child and Adolescent Services at Milwaukee Psychiatric Hospital in Wauwatosa. Dr Siegel is a member of the American Academy of Child Psychiatry and Alpha Omega Alpha.

Christopher Tashjian, MD, a family physician, will join the River Falls Medical Clinic in September. Dr Tashjian, a Minnesota native and 1985 graduate of the University of Minnesota Medical School, has announced he is leaving his practice behind in Canby, Minn, because of the state's new HealthRight law.

Kenneth Viste Jr, MD,* a former SMS president, has been elected to the board of directors of Blue Cross and Blue Shield United of Wisconsin. Dr Viste is a neurologist in private practice in Oshkosh and medical director of the Neurological Rehabilitation Unit of Mercy Medical Center, of Oshkosh; the Physical Rehabilitation Unit at St Agnes Hospital, of Fond du Lac; and the Oshkosh Care Center.[1501]

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Obituaries

George M. Kriwkowitsch, MD, of Madison, died May 28, 1992, in Madison. Dr Kriwkowitsch was born in Cherson, Russia, on March 13, 1913, and graduated from First Medical Institute in Kiev. He previously was a member of the Evangelical Hospital in Chicago and also worked for the Illinois state government for more than 20 years. Surviving are his widow, Olga; two sons, Dr George and Peter, and one daughter, Laura Ignatley.

David B. Ruehlman, MD, 87, formerly of Monroe and Kenosha, died May 10, 1992, in Sunnyvale, Calif. Born Jan 29, 1905, in Ottenheim, Ky, Dr Ruehlman graduated from Marquette University School of Medicine. His residency was completed at Meriter Hospital (formerly Madison General). He did post graduate work at Poly Clinic-New York, Harvard University, and the University of Chicago. He served in the US Navy during World War II from 1943 to 1946. He practiced medicine in Monroe from 1931 to 1955, when he moved to Kenosha where he hads medical practice until his retirement in 1978. Surviving are his widow, Hazel; a son, Dan, and a dauaghter, Patricia Siedschiag, both of Boulder, Colo.

Armin Steckler, MD, 90, Milwaukee County physician for more than 50 years, died May 25, 1992, in Brookfield. He graduated from Marquette University School of Medicine, and served his residency at Milwaukee County Hospital. Dr Steckler retired from his medical practice in Milwaukee in 1977. Surviving are his widow, Martha; three daughters, Ardene Getzel, of Brookfield, Nancy Schwab, of Seneca, SC, and Roberta Janke, of Fairfield Glade, Tenn; and two sons, Armin, of Medford, NJ, and Thomas, of Brookfield.

Gail H. Williams, MD, 67, of Marshfield, died May 21, 1992, in Marshfield. He was born July 31, 1924, in Barnett, Mo, and graduated from the University of Michigan Medical School. His internship and residency were completed at the University of Michigan Medical Center. After his residency, Dr Williams served in the US Navy from 1953 to 1955. From 1955 to 1957 he was a clinical instructor in surgery at Michigan. In 1957, he became associated with the medical staff of the Marshfield Clinic and practiced there until his retirement in 1988. Dr Williams was a fellow in the American College of Surgeons, and a member of the Wood County Medical Society, the SMS, and the AMA. Surviving are his widow, Jean; three daughters, Marty Murdoch, of O'Fallon, Ill; Kathy Gavronski, of Appleton, and Peggy Grabow, of Wauwatosa.[150th]

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THE PERSONS and organizations named below made contributions to the Charitable, Educational and Scientific Foundation from March 1, 1992, through May 31, 1992.

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In loving memory of those individuals who will grace our paths forever.
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Physicians Exchange

Continued

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The Wausau Medical Center is seeking board certified/eligible individuals in the following specialties: dermatology, family medicine, gastroenterology, hematology/oncology, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year-round as well. Write or call collect D. K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401; ph 715-847-3254. c1tfn/91

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Physicians Exchange

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Medical Meetings-Continuing Medical Education

September 19, 1992. The Milwaukee Academy of Medicine and the Continuing Medical Education Department of the Medical College of Wisconsin will present a symposium on domestic violence at the Pfister Hotel in Milwaukee, Wisconsin on Saturday, September 19, 1992. Topics covered will include recognition and assessment, community resources and legal issues relating to battered women. The keynote speaker will be Dr. Anne Flitcraft who has done pioneering research in the area of battered women. For information call Amy John, Executive Director of the Milwaukee Academy of Medicine, 414/257-8249.
g8-9/92

September 25-26, 1992: *Issues in Primary Care*, at Landmark Inn and Resort, Egg Harbor, Wis. Info: Nadine Punke,Office of Medical Education, 1000 North Oak Ave, Marshfield, WI 54449; ph 1-800-782-8581, ext 5207.
6-8/92

September 26, 1992: EMS course for physicians. One day lecture workshop on emergency medical services for physicians. Special emphasis on Wisconsin. We are interested in attracting medical directors or prospective medical directors for emergency medical services to participate in a one day conference. Faculty include four medical directors of EMS services. This program is a joint effort of the medical College of Wisconsin and the Wisconsin Chapter of the American College of Emergency Physicians. Place: Westwood Conference Center, Wausau, WI. Registration fee: $75. g8/92

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 55 cents per word, with a minimum charge of $25.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg*, copy for the August issue is due by July 1. Address communi-cations to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association*.

State Medical Society of Wisconsin

Dates and locations of
ANNUAL MEETINGS
1993-1994

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1993 - April 15-17: La Crosse Convention Center, Radisson
1994 - April 14-16: Milwaukee

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

Medical Meetings-Continuing Medical Education

October 15-18, 1992: 44th Annual AAFP Scientific Assembly in San Diego. Info: AAFP, 8880 Ward Pkwy, Kansas City, MO 64114; ph 816-333-9700; 816-822-0580 (FAX). g3-9/92

October 23, 1992: *Lyme Borreliosis Symposium*, Minneapolis, Minnesota. This symposium is designed to update physicians and other health care professionals on the diagnosis and treatment of Lyme Disease. Sponsored by Abbott Northwestern Hospital, the Minnesota Institute of Public Health, and the Lyme Disease Coalition of Minnesota. For more information contact the CME Office at Abbott Northwestern Hospital at 612-863-5461.
8-9/92

November 8-12, 1992: Ninety-Sixth Annual Meeting of the American Academy of Ophthalmology at Dallas Center. Contact: The American Academy of Ophthalmology, Meetings Dept, PO Box 7424, San Francisco, CA 94120-7424; ph 415-561-8500. g3-9/92

AMA

December 6-9, 1992: Interim House of Delegates, Nashville.
June 13-17, 1993: Annual AMA House of Delegates, Chicago.
December 5-8, 1993: Interim House of Delegates, New Orleans.
June 12-16, 1994: Annual AMA House of Delegates, Chicago.
December 4-7, 1994: Interim House of Delegates, Honolulu.

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Contents

September 1992 Vol. 91 No. 9

Opinions

513 *President's page*
Let's kick a little butt
by William J. Listwan, MD, West Bend

516 *EVP report: The view from here*
It is time to stand up and make yourself heard
by Thomas L. Adams, CAE, Madison

520 *Editorial*
National Practitioner's Data Bank
by Richard D. Sautter, MD, medical editor

520 *Letters*
Whither medicine?
by Vinoo Cameron, MD, Athens

521 Two objections to Adams' opinion
by Linda R. MacGorman, MD, Madison

521 Adams offered us excellent advice
by George P. Nichols, MD, Appleton

522 *Soundings*
Dear Betrayed Patient
by Another doctor

Scientific

527 Surgical procedures in centenarians
by Thomas H. Cogbill, MD; Pamela J. Strutt, RN; and Jeffrey Landercasper, MD, La Crosse

530 Neuroleptic malignant syndrome in a patient with neurosyphilis
by Todd Cannon, DO, and Len Sperry, MD, PhD, Milwaukee

533 *Special*
Levels of physician responsibility in diagnosis and treatment of addiction
by David G. Benzer, DO, and William Anderson, MD, Wauwatosa

Socioeconomic

537 *Public health*
Increasing incidence of prostate cancer in Wisconsin, 1980-1990
by Elise M. Jochimsen, MD; Patrick Remington, MD; and Jerri Linn Phillips, MA, Madison

Organizational

541 *After the meltdown*
Mobile clinic brings care to Ukraine
by Shari Hamilton, assistant editor

547 From municipal hospital to medical center:
Milwaukee County General Hospital, 1965-1980
by Jonathan W. Friedberg, Milwaukee and Boston

551 A glimpse into our past
by Richard D. Sautter, MD, medical editor

553 Physician briefs

556 Physician-Citizen of the Year nomination letter

557 CESF donors

Our cover: The St. Andrews Church in Kiev, Ukraine. See the related story on page 541. Photo by Bob Rashid.

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's page

Let's kick a little butt

William J. Listwan, MD

THERE CERTAINLY HAS BEEN a dramatic change in the smoking habits of Americans over the past 15 years. It is particularly noticeable at our hospitals and medical clinics where cigarette vending machines and physicians walking down the halls smoking cigarettes have disappeared. It is also noticeable in our schools, community meeting areas, and other places where I tend to socialize and make my business contacts.

When one of my daughters was married 2 years ago, she displayed several tactful posters and signs indicating that smoking was not allowed at the reception. Those who wished to smoke went outside of the hotel to have their cigarettes. Although I had more important things on my mind, I did not notice a large exodus of people after dinner or during the reception. Clearly, the people I associate with and the places where I circulate, smoking is much less common.

Although there has been a general decline in the number of people smoking in the United States, the figures still are astounding. The fastest growing sector of smokers in our country is women and every day, 2,000 more women in this country will light up a cigarette and begin the smoking habit. In the entire United States, it is estimated there will be 168,000 new cases of lung cancer in 1992. One hundred and two thousand of these will be male and 66,000 female. Overall, about 25% of Wisconsin's adult population smokes cigarettes.

Recently, the tobacco industry seems to have altered the aim of their advertising somewhat to aim at younger audiences. In a newsletter "*Smoke Free Air*,"[1] I was surprised to find out that the tobacco industry has prepared a pamphlet entitled, "*Helping Youth Say No*," and that the pamphlet was being distributed to schools and parents. The pamphlet, which I sent for and have reviewed, tells parents how they can help their children make responsible decisions.

The booklet points out that young people are not experienced enough to use the information available to them to formulate their own decisions and that they should wait until they are adults. It does point out that it is legal for adults to buy tobacco and, in a convoluted way, encourages smoking by telling children that smoking is an adult activity. No where in the booklet does it mention cancer, emphysema, or heart disease.

What a subtle and sophisticated way to advertize and encourage the use of tobacco products by our children.

Similar thoughts have crossed my mind when I read about the use of "Old Joe," the cartoon character presently used to promote tobacco products. Clearly, the

Continued on next page

'Summit conference' scheduled on tobacco

The AMA is organizing a "summit conference" to develop a national agenda for controlling tobacco use. Conferees will plan action strategies to curb smoking, especially among women, children and minorities. They will also discuss secondhand smoke in the environment, nicotine addiction and cigarette advertising. The meeting is scheduled for Jan. 9-12, 1993, at the Hyatt Capitol Hill, Washington, DC. For more information, call Tom Houston, MD, at (312) 464-5957.[150th]

Continued from preceding page
cartoon content and charm of "Old Joe" indicates to me a marketing pitch for the young male audience. There is something clearly wrong about the tobacco industry marketing their products to the youth of our country and trying to get them to be regular customers. All of this at a time when our country is struggling with increasing health care costs, a good part of which are due to tobacco use.

Recently the Wisconsin legislature passed a bill enabling companies to pass on the increased cost of health care, associated with smoking, to the individual employees who smoke. There are some rules in place to safeguard the employee from capricious cost shifting on the part of their employer or the insurance company. In West Bend, at least one employer has implemented such a policy. It certainly will bring home to the employees who smoke some of the effects of their smoking in a very real way–increased costs for their health insurance.

Exactly how the employer intends to find out who is smoking, or who has been sneaking a smoke, remains to be determined. Perhaps breath inspection on a weekly basis will be carried out? Leaving such thoughts aside, I think the principle involved is an important one and we need to be looking for ways to encourage smokers to quit smoking and to discourage those who do not smoke from starting.

A number of California municipalities have enacted entirely smoke-free restaurant policies. It has been argued that this will decrease restaurant revenues by inhibiting people from going out to eat who enjoy smoking. The Institute for Health Policy Studies at the University of California, San Francisco, has demonstrated that smoke free restaurant laws do not adversely affect restaurant sales.[2] Much like my daughter's smoke-free wedding reception, I do not feel that smoke-free restaurant policies would inhibit people from attending. They always have the option to go outside and smoke if they really need to have a cigarette.

I think that everyone of us must assume some responsibility in the continuing process of seeking to limit, and eventually eliminate, the damage done to the health of our patients by smoking. This will involve our working to eliminate tobacco subsidies for tobacco farmers, further limiting public areas where smoking is tolerated, and strong educational efforts aimed at our individual patients to help them kick the tobacco habit.

All of us need to make sure that our patients know that we are strongly behind the anti-smoking and anti-tobacco campaigns of the AMA and our State Medical Society. Display of placards in our waiting rooms and examining rooms, the wearing of lapel pins, and any personal support we can give to reasonable legislation needs to be encouraged. More importantly, we must verbally question our patients about their use of tobacco, offer data if they do not understand the significance of their tobacco use, and offer our support if they wish to quit using tobacco.

Let's also work to enact legislation preventing the tobacco industry from advertising to youths, either directly or in more subtle ways like the pamphlet I described earlier. It may be that the only answer is to eliminate all public advertising of tobacco products. This remains to be seen.

It's time we stopped blowing smoke and started blowing "Old Joe" away.

AMA resolution on tobacco

Tobacco advertising aimed at children

RESOLVED, That the American Medical Association call on the R.J. Reynolds Tobacco Company and other tobacco companies to refrain from engaging in advertising practices which either intentionally or inadvertently target children; and be it further

RESOLVED, That the AMA support all efforts to encourage the R.J. Reynolds Tobacco Company to specifically abandon the "Old Joe Camel" advertising campaign; and be it further

RESOLVED, That the AMA vigorously defend all attacks by the tobacco industry on the scientific integrity of AMA publications; and be it further

RESOLVED, That the American Medical Association support the concept of free of charge advertising space for anti-tobacco public service advertisements.

In the workplace

RESOLVED, That the American Medical Association use active political means to encourage the Secretary of Labor to swiftly promulgate an Occupational Safety and Health Administration (OSHA) standard to protect American workers from the toxic effects of environmental tobacco smoke in the workplace, preferably by banning smoking in the workplace.

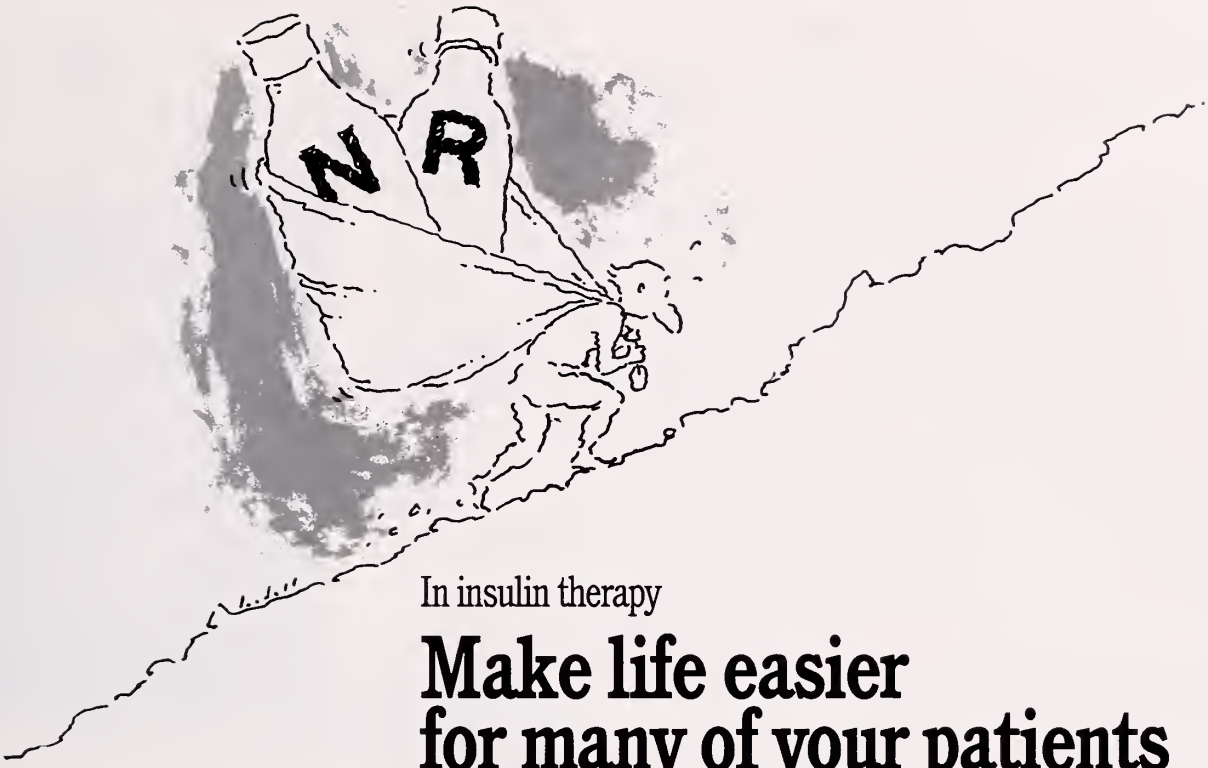
On international flights

RESOLVED, That the American Medical Association join with other concerned organizations to seek a Federal Aviation Administration ban on smoking on all flights originating from or destined to the United States; and be it further

RESOLVED, That the AMA, the World Health Organization, and the World Medical Association work with the medical department of the International Civil Aviation organization (ICAO) to ban smoking on all international flights.[150th]

References

1. *Smoke Free Air.* Smoke Free Educational Services, Inc. Summer 1992.
2. Glantz S, Smith L. *The Effect of Ordinances Requiring Smoke Free Restaurant Sales in California.* Institute for Health Policy Studies, University of California, San Francisco.[150th]



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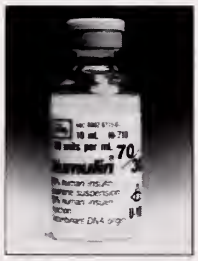

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EVP report: The view from here

It is time to stand up and make yourself heard

In this election year, our thoughts naturally turn to government. The recurring motif of this election year seems to be the unpopularity of government officials at all levels. So if you are feeling nonplussed about the upcoming elections, you are not alone. The mood of the electorate is extremely pessimistic. A national survey this spring found that 77% of those polled said that the country is on the wrong track; only 16% said they thought it was on the right track. That is the lowest percentage of approval since 1980.

The US Congress is feeling the heat of the public's wrath. Sixty percent of those surveyed said they would vote to replace the entire Congress, including their own senators and representatives.

While Congress-bashing has become a national sport, the president is feeling some heat of his own, as evidenced by his standing in the polls (at this writing he is 20 percentage points behind his challenger).

The public's hostility toward Washington, however, also carries over to elected officials at the state level. A focus group conducted on a proposed amendment to Wisconsin's constitution that would change the uniform taxation clause showed that, although both the governor and the Legislature are blamed for state government's inability to address the public's needs, the Legislature is blamed more.

Unless something happens between now and election day to change the mood of the electorate, incumbents at all levels of government will be unusually nervous the evening of Nov 3. With a high turnout expected at the polls because of the presidential election, it remains to be seen whether voters will actually make wholesale changes. Historically, even when voter dissatisfaction is high, upwards of 90% of incumbents running for re-election to Congress are successful in their bids.

The issue of reforming the health care delivery system continues to carry great symbolic weight in this political season. An April national opinion poll found that 45% of Americans favor some form of national health insurance; 26% said that the government should provide health care for those who cannot afford it; and 20% said that the government should continue with its current level of involvement.

Again, the future of this issue will be determined by who is elected in November. George Bush has proposed an elaborate plan that would rely on competition between prepaid providers, like HMOs, to control costs. The plan would provide poor families with tax credits to buy basic medical insurance. It would also encourage small employers to buy insurance through large purchasing cooperatives, which would help stem the perverse practice by which some companies negotiate low premiums by hiring only healthy workers.

The president refuses, however, to take the tax-related steps needed to make his plan work. He would not make the proposed tax credits large enough to guarantee affordable coverage. He would not limit the deductions for premiums, which is a good way to encourage the public to be smarter health care consumers. And he would not eliminate tax deductions for employer-based coverage if the company refused to join a purchasing cooperative.

Meanwhile, Bill Clinton has endorsed the play-or-pay plan, whereby employers would be required to provide health insurance to workers or pay a tax to enroll them in a public plan. Unfortunately, the governor has not yet articulated any ideas for encouraging more prudent behavior on the part of health care consumers.

Regardless of the relative merits of these ideas--and intelligent people can find good things in both--we should be encouraged that the nation's leaders are finally talking about health care.

Thomas L Adams, CAE

Organized medicine was the first to identify the delivery system's problems and the first to begin thinking creatively about solutions. That was several years ago, and for a long time it felt as if we would always be a voice in the wilderness. Now that our voices have been heard and others are willing to explore the problems we have so long encountered, we must be certain that we are heard in the current and future searches for solutions.

Your State Medical Society has formed its Task Force on Health Care Systems Reform to join that search with vigor. The task force has been active, open and spirited, and I think we can expect exciting things to emerge from its study and deliberation.

The SMS will use the work of this task force to launch a major reform proposal in the spring of '93. The Wisconsin Hospital Association and others are expected to do likewise, and we must be prepared to debate the issue. We must be prepared to persuade the public and elected officials that ours is the most prudent method of achieving reform. To do that, we need to

Continued on page 518

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have been involved–from the SMS lobbyists in Madison to the SMS members in the far reaches of Wisconsin's northern forests.

This means getting involved: making contributions to campaign funds, attending fund raisers, stuffing envelopes, putting up yard signs, knocking on doors, and talking to our friends and associates. Your conscience and your resources will determine who you will support, as well as how and to what extent you will support them. The important thing is that you are involved.

You may ask: What is the use? Will anything actually get done, regardless of who wins in November? That remains to be seen. Given the experience of the past several years, we can hardly be blamed if we are pessimistic. I am, however, decidedly optimistic. Maintaining my faith in both the American people and the American system of government, I believe that the next two or three general elections will revive Congress and to be truly responsive to problems ranging from health care to the deficit.

Having said that, though, I think it is important for us to step back and examine how we get in this mess. How did we become saddled with a government that so miserably falls short of our hopes and dreams? What lessons might we take from this?

I do not believe that the cause is found in some flaw in our political system, as some are suggesting. The system has not failed, but some of us have failed the system. We have let politics become a quagmire and then avoided it because it was a quagmire: ours has been a double guilt.

It may be cliche, but it is no less true that if we are not part of the solution, we are part of the problem. Bad officials are elected by good citizens who don't vote. Politicians are as good as you are, for the way you vote creates politicians. There simply is no substitute for involvement.

As the great journalist Edward R. Murrow once said, "our major obligation is not to mistake slogans for solutions." I think a useful guide in selecting a candidate for which to vote is to remember that, when running for office, a politician wants to *be* something and a statesman wants to *do* something.

We need to elect men and women to all levels of government who are more committed to public service than to advancing their own reputations or careers. We need to involve men and women from all corners of our communities in the political system.

Most importantly, we need to involve ourselves. Do it for your state or country, for your patients or colleagues, for your neighbors or family–even do it for yourself–but do it.[150th]

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Editorial

National Practitioner's Data Bank

The National Practitioner's Data Bank (NPDB) is to contain information relative to medical malpractice, accumulated from every state in the union, at a central location. While this is not an unreasonable idea, the system is totally unworkable at present and probably will never be of any value except, perhaps, to plaintiff's attorneys.

The NPDB is a perfect example of a bureaucratic nightmare or a perfect Catch 22. To be licensed by the Wisconsin Medical Examining Board, house officers completing their first year, or PG-1, are required to query the NPDB personally. If, and when, the data bank responds, the applicant is required to forward the query unopened to the MEB.

One must first consider it extremely unlikely that house officers completing their PG-1 will have information in the data bank; therefore, one must wonder what purpose the query might serve. It would be of great interest to me to know how many of the more than 15,000 graduates in their PG-1 year are involved in any malpractice action. I would guess the number is extremely low.

Another problem is the response time to queries from physicians who have been in practice for several years. Responses may take months and are sometimes unavailable–both instances unnecessarily delaying the licensure of physicians. The implication of not receiving information from the NPDB is that there is something wrong with the applicant's qualification: In other words, physicians are presumed guilty until proven innocent.

The MEB should petition this agency for an exemption of all PG-1 physicians. Furthermore, unless the NPDB can respond to queries within two weeks–a feat, to date, the NPDB has found impossible--this project should be terminated.

–Richard D. Sautter, MD
medical editor

Letters

Whither medicine?

To the editor: Over the number of years I've practiced in Wisconsin, it has been my observation that we have paucity of real leadership, and very often physicians are far too content in practicing medicine with their heads hidden in the sand. Physicians are very reluctant to speak up on issues of utilization, accountability, and conflict of interest in our business dealings, etc. My observation is mainly on primary care and availability of primary care and the emergence of a number of satellite centers and primary care centers affiliated with other major centers.

I'm not quite sure this is the way to deliver effective primary care. Often, there is more emphasis on referral considerations and channeling of patients to one particular institution. In the real sense, this is really not competition.

Just this week, I was taken aback when a patient of mine–who has COPD and has had a previous myocardial infarction and requires in home oxygen because of her PO^2 of about 45–was approached by one of these parahealth professionals and possibly a herb and vitamin dealer, who told her that she could drink this "Liquid Oxygen" product that will improve her vitality and give her more oxygen. In fact, this young lady wanted to buy the product because she felt the nasal oxygen was too inconvenient. This is quite deplorable and, in my opinion, our society is no different that the societies in the third world countries exposed to witchcraft, etc.

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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Just the same day, I looked at a brochure where, in the heart of central Wisconsin, we have a university program offering family physicians (for a fee of $450) a course in colposcopy and loop diathermy. This is unimaginable to me because here we have a shortage of family physicians and good primary care and we are training our family physicians to do more and more procedure care which is often over-used, not cost-effective, but fairly lucrative.

Consequently, we have a situation where good real primary care is being delegated to health paraprofessionals, chiropractors, vitamin shops, and a variety of other such places.

I had recently seen another similar program where family physicians were being taught EGDs. Throughout my 12 years of postgraduate training, I have come to understand that such procedures first of all not only require continued training, but require 50 to a 100 procedures a year to maintain proficiency. I can't imagine a family physician in Wisconsin spending that much time on these procedures unless these procedures are being over-used.

We, as physicians, need to look at our cost effectiveness and the mushrooming of such procedure-oriented care (eg, colposcopy). I think if we standardize proper physician training, standardize proper pap evaluation and proper preventive care, the need for colposcopy would be limited and could, and should, be done by a limited number of physicians who do this procedure efficiently and effectively. Unfortunately, because of our attitudes and lack of discipline within the profession, we all are guilty of practicing such "passe" medicine.

–Vinoo Cameron, MD
Athens[150th]

Two objections to Adams' opinion

To the editor: I appreciate that Thomas Adams' chief objective in his recent column ("Secretary's report: But she's my doctor!" *Wis Med J.*1992;91 (7):334-335) is to urge physicians to take care of their own health. We sometimes need the reminder. But I have two objections to the column to voice.

First, withholding a person's name creates anonymity only when that person could not otherwise be identified from available information. Coming so soon after the physician's death, her identity is unmistakable to anyone who knew her, and quite a few of us knew her. This lack of anonymity seems disrespectful of the physician and somewhat offensive to at least some of her friends.

Second, while it is true that patients benefit from their physicians' good physical and emotional health. I believe it is unwise to suggest that our patient responsibilities might suffice as the major motivation to care for ourselves. In fact, our good health usually depends on limiting our responsibilities. We need to take care of ourselves simply because it is a basic task of life, for patients and physicians alike. It is a task we ultimately must accomplish for ourselves alone.

–Linda R. MacGorman, MD
Madison

Editor's note: The decision to withhold the victim's name was made out of respect for the victim and her family, as there are thousands of *WMJ* readers who did not know the nature of her passing. Any "lack of anonymity" must be attributed to sources other than the *WMJ*. Interestingly, more than one identity has been affixed to the victim by physicians responding to Adam's editorial.[150th]

Adams offered us excellent advice

To the editor: In his July "Secretary's Report" (*Wis Med J.*1992;91(7): 334,337), Thomas Adams showed us a beautifully expressive letter he had received from a patient whose perceptions were shattered when her fine doctor committed suicide. Adams' message was to remind us that we doctors should also take care of *our*selves–excellent advice.

But there is another message here too: A reminder that what we have learned now about suicide helps clear away some of the anguish, the anguish that pains the survivors, and feeds the media. We know now that suicide is almost always the result of a sickness, rather than of someone's weakness or failure to cope.[1] The sick one can be anyone, a doctor as well as a patient.

Understanding this may give solace to that poor, distraught patient who wrote to Adams. Most likely, her doctor didn't fail; her doctor got sick.

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The sickness which can lead to suicide is usually a highly treatable depressive illness, but often undiagnosed. We can sometimes look at patients and even in the bathroom mirror without recognizing it. The World Health Organization has good reason to call depression "the world's most treatable untreated disease."

Partly because of the persistent outdated stigma, its symptoms are too often hidden and misinterpreted, but it can attack our mightiest citizens, destroying their outlook and judgment. We think of diagnosing depression of course when people are in a down mood[2], but we should also think of depression in anyone who presents us with a heavy personal problem, in those who complain too much, and in people with multiple symptoms, with stubborn pain, or excessive anxiety. If the criteria for diagnosing depression seem hard to remember, then the Beck Inventory depression questionnaire can be of real help.

And yes, people with depressive illness can sit on either side of the table.

–George P. Nichols, MD
Appleton

1. Roy A. Suicide. In: Kaplan H, Sadock B, eds. Comprehensive Textbook of Psychiatry. Philadelphia: Williams & Wilkins Pub Co. 1989:1414.
2. Mondimore F. Depression, the Mood Disease. The Johns Hopkins University Press, Baltimore, MD 1990.[150th]

Soundings

Dear Betrayed Patient

THANK YOU FOR THE LETTER you wrote the week after your doctor killed herself. Her death is a tragedy, but good can come out of your expression of perplexity, anger, and sorrow.

I can't speak for your doctor, of course, but I thought you might like to hear, from a doctor who almost killed herself, how such a thing could come to pass.

I developed major depression. One of the symptoms of this mental illness is the desire to kill oneself. Ninety percent of persons who kill themselves are suffering from a mental illness at the time of death, and major depression is the illness present in the majority. Major depression is common; 15% of the general population suffers at least one episode during a lifetime. Medical students and doctors have a higher prevalence of depression than most. And women doctors get more depression than men doctors. About half of women physicians suffer at least one episode.

Now major depression is an illness for which good treatment is available. A lot of depressed persons don't realize that their despair is part of a treatable illness, but doctors know about the illness and know that treatment provides effective and often dramatic relief. So how could a depressed doctor not seek treatment for herself?

In my case, I believe that my reluctance to seek appropriate care and my nearly succumbing to self-murder were at least partly a product of what it takes to become and to remain a physician in our society.

My training in self-sacrifice and self-neglect started in childhood. My father was an emotionally distant engineer, minimally involved with marriage or family. My mother was a homemaker with many children, including a chronically ill child with "special needs." My mother believed that she should and could and did singlehandedly provide everything her family needed in the way of emotional sustenance. But the unacknowledged truth was that she was chronically overwhelmed. I took on the role of "the helpful one," denying my own needs and assisting my mother. By my early teens, I was my mother's closest confidante, listening for hours daily to her woes. This "helping" was at great personal cost to me, but it was the way I got appreciated in my family.

I am intelligent and industrious, so it is not surprising that I chose for a career the "helping profession" of physician.

The training in neglecting (and despising) my human self and my normal, human needs was continued and reinforced in medical school and residency. In fact, there were new elaborations: in addition to neglecting my emotional needs, I learned to neglect my needs for food, sleep, sex, and physical exercise.

Having some compassion for myself, I did from time to time make protests, but I was consistently punished or shamed for them. For example, I protested the inhumane schedule of the required medical school rotation in the big city hospital emergency room. We had to work 36 hours (without sleep) in the emergency room, alternating with 12 hours off, for one month.

Other students agreed that those working conditions were inimicable to good health and were likely to result in clinical errors, surliness toward patients, and strained marriages and other interpersonal relationships. I agreed to be spokesperson to request a change in the requirements. When I stood up and petitioned the course director at our orientation session, he denigrated and humiliated me with insulting remarks about my laziness, lack of motivation, and disinterest in learning. Then he asked scathingly, "Does any other medical student in this

room feel the same way?" There was dead silence.

Actually, the course director did finally allow the option (for lazy, unmotivated students) of 24 hours on duty alternating with 24 hours off. I selected this "light duty" option, but nonetheless had visual hallucinations while driving home some mornings, due to sleep deprivation.

During residency, I had a 90 to 100 hour work week, which was, and still is, usual. Although not overweight, I lost 20 pounds during the first month because I was so busy saving lives that I did not have time to eat.

Thanks to the flexibility of my residency director, I did something which was almost unheard of then (the 1970s) but which is becoming more common now: I did my last year of residency half time, over 2 years, because I gave birth to a baby. But I had to pay penalties for this choice, which my fellow residents considered inexcusable self-indulgence. I had to make up the 2 months I stayed home with my newborn (which a fellow resident referred to as my "vacation"). And I had to take twice as much night and weekend call my last year as any other resident (full call duty both of the years I worked half time).

After residency, I was turned down for clinic partnership because I was only working part time, a mere 60 hours a week. The board of directors of the clinic was delighted with the quality of medical care I was providing, but I would not be allowed to become a member of the service corporation unless I brought in as much money as a full-time physician. (I was nursing my second baby at the time.) The message I understood was: I was not giving enough.

I could go on with many other examples, but I think you get the idea.

You wrote, "Maybe doctors think they should only give and never take." You're right, many of them do. I did, especially when I was depressed. I believed that attending to the needs of others was the only justification for my existence. I didn't deserve to ask for anything for myself. I had to be a saint. Yet naturally, after all those years of self-neglect, I was full of

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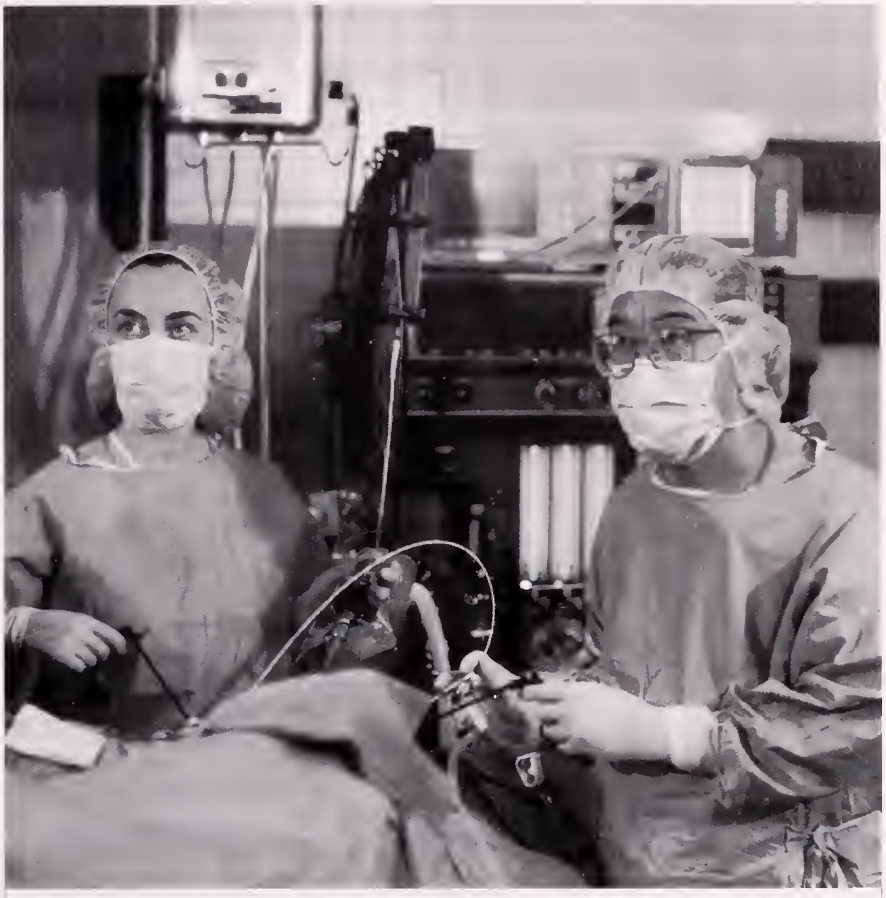

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Continued from preceding page
resentment and a nasty, unsaintly desire to *demand* that finally I be taken care of and murderous *rage*. Since this resentment and demandingness and rage were antithetical to the saint I though I had to be, I felt tremendously ashamed. I feared there was no good in me. When provoked by having my needs disregarded, I was afraid to assert myself. I was thrown into a panic lest I be unable to restrain my rage. I was convinced that I had to die.

This is a sad tale, which can have a tragic ending. I stepped out of it by getting myself to some good mental health care. My treatment has included both medication and psychotherapy. Also crucial has been seeking support from family, friends, support groups, selected colleagues, and clergy.

I am no longer depressed, but I am still vulnerable to interactions where the implication seems to be that I don't deserve to have my needs respected and attended to. In those situations, I tend to have panic attacks and to become suicidal.

Your letter, though written about someone else, contains what I need to hear in such emergencies. Your beloved doctor *did* give enough, and what she gave was good. It did not diminish her worth or the goodness of what she was able to provide if she needed to pause from giving, to replenish herself.

I'll keep your letter close at hand. Thank you very much for writing it.
Sincerely,
Another doctor[150th]

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Surgical procedures in centenarians

Thomas H. Cogbill, MD; Pamela J. Strutt, RN; and Jeffrey Landercasper, MD, La Crosse

Sixteen patients 100 years of age and older underwent surgical procedures at a single institution during the 11-year period ending December 1991. There were 11 (69%) females and five males. Patient ages ranged from 100 to 104 (mean, 101.1 years). Procedures included six ophthalmologic operations, three permanent pacemaker implantations, three compression hip screw fixations, two leg amputations, one hemiglossectomy, and one cystostomy. There was one (6%) perioperative death. Long-term follow-up was established for each patient. One-year survival rate in these 16 centenarians was 69%. We conclude that selected patients 100 years old and older can survive certain surgical procedures with acceptable perioperative and long-term results. *Wis Med J.* 1992;91(9):527-529.

Due to increases in total population and life expectancy in the United States, the very elderly comprise the fastest growing segment of our population. Surgical procedure rates have also risen rapidly in this group of people over the last two decades.[1] The combination of rapid population growth and increased health care use in these elderly citizens will potentially have a profound influence on the United States' health care economy.[2,3]

Persons 100 years of age and older, or centenarians, represent a select subset of this population. The number of centenarians currently residing in the United States is approaching 50,000. Furthermore, it has been predicted that there will be 108,000 people over 100 years of age in this nation by the year 2000.[4] By the year 2080, there may be as many as 1.5 million to 5 million centenarians in the United States, depending upon the accuracy of assumptions used in estimates performed by the Bureau of the Census.[4] As these people develop medical and surgical conditions, physicians will need outcome data to assist in making appropriate therapeutic, social, ethical, and economic decisions.

In an effort to characterize the types and results of procedures currently performed in the very elderly, we undertook an analysis of all centenarians who underwent operations at a single institution. Both perioperative and long-term outcomes comprised the focus of this report.

From the Department of Surgery, Gundersen Clinic, Ltd., La Crosse. This paper is based on a presentation at the April 25, 1992, meeting of the Wisconsin Surgical Society. The authors gratefully acknowledge the financial support of the R. James Trane Surgical Data and Research Center of the Gundersen Medical Foundation. Reprint requests to: Thomas H. Cogbill, MD, Gundersen Clinic, Ltd, 1836 South Ave, La Crosse, WI 54601. Copyright 1992 by the State Medical Society of Wisconsin.

Patients and methods

Lutheran Hospital is a 400-bed referral facility serving 19 counties in southwestern Wisconsin, southeastern Minnesota, and northeastern Iowa. The hospital is staffed by the 230 full-time physician specialists of the Gundersen Clinic.

Study design consisted of a retrospective review of the inpatient hospital chart and outpatient clinic record for all patients 100 years of age and older who underwent a surgical procedure requiring anesthesia in either of two primary operating suites.

During the 11-year period ending December 1991, 16 centenarians meeting these entry criteria were identified. Charts were studied to determine patient age, sex, admitting diagnosis, other medical illnesses, procedures, anesthetic agents, perioperative complications, preoperative living situations, discharge destination, duration of hospital stay, and, if appropriate, the date and cause of death. The current status for each surviving patient was established by telephone questionnaire.

Results

During the 11-year study period, 16 centenarians underwent surgical procedures at the Gundersen/Lutheran Medical Center (Table 1). There were 11 (69%) females and five males. Patient ages ranged from 100 to 104 years, with a mean of 101.1 years. Pre-existing medical illnesses were apparent in 15 (94%) patients, including 11 with arteriosclerotic cardio-

vascular disease and two with aortic valve stenosis. Significant senile dementia was evident in four.

Procedures performed included cataract extraction and lens implantation in six patients, permanent pacemaker placement in three, compression hip screw fixation of femur fractures in three, leg amputation in two, hemiglossectomy in one, and suprapubic cystostomy for obstructing prostate carcinoma in one. Local anesthetic agents were used in nine (56%) patients, and general endotracheal anesthesia was administered in seven.

The only perioperative complications and the sole perioperative death occurred in a 101-year-old woman who underwent hemiglossectomy for the treatment of a large epidermoid carcinoma of the tongue. Postoperative deep vein thrombosis and stroke led to pulmonary aspiration and death on the 14th postoperative day.

Overall perioperative mortality in this series was therefore 6%. The duration of hospital stay in the 15 remaining patients ranged from one to 14 days (mean, 5.3 days).

The preoperative and discharge living situations were determined for every patient (Table 2). The majority were nursing home residents before surgery and returned to their original facility upon discharge. Of four centenarians living at home prior to surgery, one died in the hospital, one required temporary nursing home placement, and one elected to live with his daughter. The remaining patient continued to live in her own home until she died at age 103.

Long-term follow-up was established in each instance (Table 1). All six patients who underwent cataract procedures survived at least 1 year. Two remain alive at ages 102 and 103, respectively. All three patients in whom pacemakers were placed survived at least 1 year. One is still alive at age 106. Although all three patients treated with compression hip screws have died, they lived an average of 4 years after surgery; two until the age of 106. Both patients requiring amputation for unrelenting leg pain and sepsis were dead within 2 months following these procedures. For the entire series, survival at 1 year was 69% (11 of 16 patients). This was not different from the 68% 1-year survival predicted for age- and gender-matched controls.[4]

Discussion

Centenarians are members of the fastest growing group of Americans due to increases in overall population and longer life expectancy. These remarkable individuals represent a select subset of humans with exceptional physical reserve. Their average additional life span is greater than 4 years.[4]

Several centenarians have divulged their secrets to longevity. One states: "Keep your feet warm, your head cool, your bowels open, and trust in the Lord."[5] Another credits genetic composition in his explanation: "If you plant a strong plant, it grows."[5] Regardless of the specific reasons that an individual lives 100 or more years, he or she may ultimately develop conditions which require medical or surgical intervention.

As this sector of the population continues to grow, the medical, philosophical, sociological, and economic issues of providing health care to these oldest old patients will become more pressing. On a larger scale, Longino has written that "it is up to the nation's policy makers, planners, and businesses to make the independence of the very old possible without

Table 1.–Clinical data for 16 centenarians who underwent surgical procedures.

Patient	Age	Sex	Procedure	Anesthetic	Complications	Hospital Stay (Days)	Follow-Up
1	100	F	Cataract/Lens Implant	Local	None	1	Dead at 30 months
2	104	F	Cataract/Lens Implant	Local	None	4	Dead at 35 months
3	100	M	Cataract/Lens Implant	General	None	4	Deat at 17 months
4	100	F	Cataract/Lens Implant	Local	None	1	Alive at 34 months
5	104	F	Cataract/Lens Implant	Local	None	1	Dead at 24 months
6	100	F	Cataract/Lens Implant	Local	None	1	Alive at 17 months
7	103	M	Permanent Pacemaker	Local	None	2	Dead at 16 months
8	103	M	Permanent Pacemaker	Local	None	2	Alive at 24 months
9	100	F	Permanent Pacemaker	Local	None	7	Dead at 34 months
10	100	F	Compression Hip Screw	General	None	14	Dead at 78 months
11	101	F	Compression Hip Screw	General	None	13	Deat at 57 months
12	101	F	Compression Hip Screw	General	None	10	Dead at 9 months
13	100	M	Above Knee Amputation	General	None	9	Dead at 1 month
14	100	F	Below Knee Amputation	General	None	6	Dead at 2 months
15	101	F	Hemiglossectomy	General	Stroke/DVT* Aspiration	14	Died in Hospital
16	100	M	Suprapubic Cystostomy	Local	None	5	Dead at 3 months

*DVT - Deep vein thrombosis

bankrupting young generations."[3] Solutions to these challenges will be difficult to evolve. Contemporary outcome data concerning treatment of the very elderly will be necessary to propose realistic answers.

Studies of surgical results in the very old have recently been reported. These have included outcomes of procedures in patients older than 90.[1,2,6] Furthermore, the results of operations in a relatively small number of centenarians have been the focus of two papers.[7,8] Several conclusions from these studies are evident. Selected procedures with inherently low morbidity and mortality may be safely performed in appropriate very elderly patients with acceptable short and long-term results. Perioperative mortality rates in these recent studies range from nil to 20%.[1,2,6-8] Mortality following emergency procedures is significantly higher than after elective operations.[2] The low perioperative mortality rate following elective procedures is even more impressive in the face of a very high prevalence of chronic medical illnesses. Those pre-existing medical conditions most often associated with perioperative complications and deaths include cardiovascular disease, pulmonary problems, and thromboembolic phenomena.[2,7]

Long-term survival of the very elderly after surgical procedures has been reported to be equivalent or better than that expected at 1 year or 5 years for the general population matched for age and gender.[1,2] The enhanced survival noted by Warner and associates in patients more than 90 years old who underwent surgical procedures may be due to preselection bias or actual improvement in their condition as a result of the operation.[1]

Overall 1-year survival in our series was 69%. We found that the long-term results were dependent on the type of procedure. Patients with advanced vascular disease requiring amputation for rest pain and impending sepsis had very limited survival, but all patients undergoing relatively simple ophthalmologic procedures or pacemaker implantations lived at least 1 year after surgery. We also discovered surprisingly excellent outcomes in the three patients with femoral neck fractures treated by compression hip screw fixation. Their mean survival after surgery was 4 years. Encouraging functional results in these individuals have been reported by Cohen and associates as 61% of their elderly patients with hip fractures were able to walk after fixation.[6]

While our small experience does not justify the indiscriminate application of invasive procedures in patients more than 100 years of age, we have demonstrated that selected centenarians can successfully undergo certain surgical procedures. More than any other group of patients, the benefits of these operations to improve the quality and duration of life must be carefully balanced against the potential morbidity and mortality.

In our series, overall perioperative mortality rate was gratifyingly low at 6%. Long-term outcome was also excellent with survival at 1 year in 69%. The philosophy of offering surgical treatment to this remarkable group of very elderly patients in order to achieve potentially improved quality of life despite somewhat limited duration of survival can best be summarized with the following quote: "One or two years in a lifetime is not much in the middle, but is an awful lot at the end."[7]

Table 2.–Preoperative and discharge living situations for 16 centenarians.

	Preoperative	Discharge
Nursing home	10	11
Own home	4	1
Family member	2	3

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Neuroleptic malignant syndrome in a patient with neurosyphilis

Todd Cannon, DO, and Len Sperry, MD, PhD, Milwaukee

Neuroleptic malignant syndrome (NMS) is a catatonic-like syndrome of uncertain etiology occurring in patients taking dopamine blocking medications. The paper describes how NMS presents and is treated and reports the case of a patient with undetected neurosyphilis who developed NMS. The case highlights the need for a thorough organic evaluation of all patients with initial-onset psychotic features and suggests the possibility of a CNS cofactor—neurosyphilis—initiating the NMS as proposed by other researchers. *Wis Med J*.1992;91(9):530-532.

NEUROLEPTIC MALIGNANT syndrome (NMS) is a relatively uncommon, idiosyncratic, catatonic-like syndrome occurring in patients treated with dopaminergic blockers, most usually neuroleptics.[1] This paper describes NMS in terms of its core symptoms, differential diagnosis, course, etiology, and treatment. It reports a case of NMS in a patient with undiagnosed syphilis and supports the proposed theory of organic cofactors necessary to induce NMS in patients taking neuroleptics.[2] Finally, recommendations for any physician who prescribes neuroleptics or other dopaminergic agents are discussed.

Presentation

NMS presents with some or all of the following core symptoms: hyperpyrexia—with temperatures over 38.3° C (101° F), autonomic instability with labile hypertension, pipe-like rigidity in all muscle groups, mental status changes, and seizures.

Symptoms characteristically occur within the first 2 weeks of beginning an anticholinergic agent—typically a neuroleptic—or while the drug dosage is increased.[3-5] NMS can, however, occur any time during neuroleptic usage. The reported incidence of NMS in patients taking neuroleptics is between 1% and 2%.[5]

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Characteristic laboratory findings associated with NMS include an elevated creatine phosphokinase (CPK) in 50% of cases in the range of 2,000 to 15,000 units or higher; and leucocytosis peaking 1 to 2 days after the start of NMS not associated with a left shift. Furthermore, electrolyte changes are noted, particularly elevated serum calcium and decreased serum phosphorous. Cerebral spinal fluid protein can show elevated protein levels. Urinalysis may show hyaline casts, white and red blood cells. Elevated blood urea nitrogen and creatinine with a relative dehydration has also been noted in patients with NMS.[1,4]

Malignant hyperthermia (MH) and NMS are sometimes confused. MH is primarily mediated peripherally via accessory muscle contraction and related to abnormalities in the muscle tissue membrane, whereas NMS is primarily mediated centrally via dopaminergic blockade with symptoms of rigidity and tremor originating from blockade of the nigrostriatal system. The nigrostriatal system involves dopaminergic cell bodies located in the substantia nigra with axons projecting into the putamen and the caudate nucleus. This may be the system involved in the side effects of antipsychotics including tardive dyskinesia.

Peripheral mechanisms found in both NMS and MH include motor effects on peripheral vascular tone, heat transfer from body core to body surface, water evaporation, and thermogenesis through shivering and non-shivering. Neuroleptic blockade may disturb both peripheral and central mechanisms.

Course

While MH is precipitated by agents such as halogenated anesthetics and succinylcholine, the onset of NMS is associated with dopaminergic blocking agents. NMS is commonly associated with high potency neuroleptics like haloperidol and fluphenazine, but any neuroleptic can precipitate NMS. Genetic factors are implicated in MH, whereas none seem to be in NMS.[5]

Furthermore, the length of clinical course differs between NMS and MH. In MH, there is a rapid development of muscle rigidity and fever usually within minutes of exposure to halogenated inhalation anesthetics or succinylcholine, whereas the clinical picture usually develops over a matter of days to weeks in NMS.

Treatment

The treatment of NMS includes immediate intervention, discontinuing the neuroleptic agent and starting the patient on a dopamine agonist. Drug treatment is usually with the dopamine agonist bromocriptine, but also many include dantrolene, lorazepam, and propranolol. Use of supportive measures–including cooling blankets, ice water enemas, ice packs, chilled IV fluids, antipyretics and supplemental oxygen–may be necessary.[5]

The recovery time from NMS is variable and can range from a few days to documented cases of several months. The most severe cases of NMS in longevity are related to the decanoate preparations of fluphenazine and haloperidol. The reoccurrence of NMS is an enigma.

Recent studies[2] suggest that the use of high potency neuroleptics may not be associated with higher incidence of NMS as previously believed. Re-challenging patients who had documented cases of NMS with high potency neuroleptics in a recent long-term study by Pope and his colleagues[2] demonstrated that patients

tolerated the re-challenge without reoccurrence of NMS—some as long as 11 years. Pope and others theorize the possibility of organic cofactors, infections, dehydration, tumors, etc, responsible for initiation of NMS in patients taking neuroleptics.[2]

Case report

The patient was a 33-year-old man with a history of behavioral changes that began 1 year prior to admission. These included auditory hallucinations, talking to himself, and laughing frequently without obvious reason. Previously, the patient had a good work history at a manufacturing company and was involved in a long-term relationship. There was no personal or family history of psychiatric or substance disorders and his medical history was unremarkable.

The patient was diagnosed with a schizophreniform disorder and treated with fluphenazine, 5 mg twice daily, eventually adding 2 mg of perphenazine and 10 mg amitriptyline at bedtime. A 4-month trial on these medications was only partially successful in controlling his psychotic symptoms.

An inpatient admission to the neurology service of a regional medical center was arranged because of progressively worsening resting tremor and muscle rigidity resulting in loss of balance and falls. The initial diagnosis was neuroleptic-induced Parkinson syndrome. Although still taking the perphenazine and amitriptyline, the fluphenazine had been discontinued some weeks prior to admission.

The mental status examination noted the patient to be alert and oriented, slightly obese, with flat affect and neutral mood, uncontrollable drooling, rigid posture, and tremors in both hands. Cogwheel rigidity of the extremities and a difficulty speaking were observed.

An extensive neurological evaluation was begun and both medications suspected of causing the extra pyramidal side effects were discontinued. CT and MRI of the patient's head revealed no abnormalities and screening laboratory values were unremarkable. A lumbar tap found elevated CSF values: protein 52, glucose 78, WBC 12, and RBC 2. Serum and CSF VDRL titers, as well as CSF cultures, were ordered.

A psychiatric consultation was requested on the second day to evaluate the Parkinsonian syndrome. The consultant recommended treatment with diphenhydramine 50 mg. Within 20 hours, the patient began experiencing marked confusion, tachycardia, diaphoresis, hypertension, and lethargy. He was transferred to intensive care unit for what initially appeared to be an anticholinergic crisis and the diphenhydramine was stopped. In addition to the muscle rigidity, autonomic instability with labile hypertension were noted. After 24 hours, the

Continued on next page

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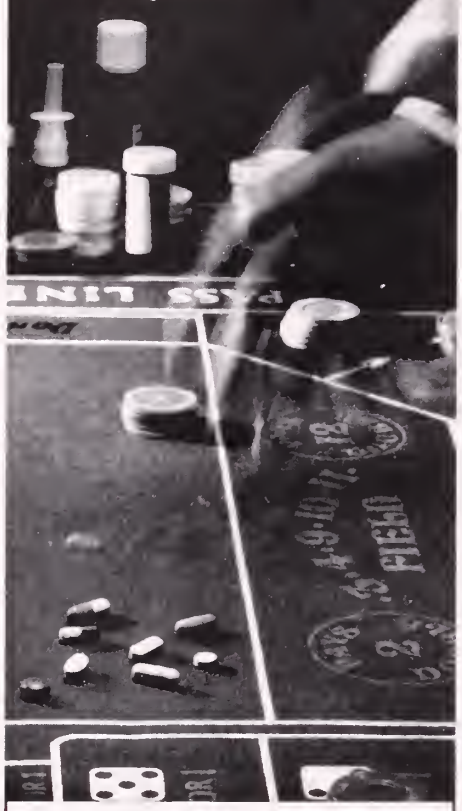

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patient was returned to the neurology service.

A CPK of 2,854 was reported, although an EKG showed no acute changes and isoenzymes were of MM fraction only. CSF and serum VDRL titers were positive and a diagnosis of neurosyphilis was made. Twenty-four hours later, another CPK was 4,428 and WBC count went from 5,800 to 14,500.

Considering his clinical picture and laboratory findings a diagnosis of NMS was made. The patient was begun on 24 million units IV penicillin to treat the neurosyphilis, and on bromocriptine, increasing the dose to 5 mg qid. He showed extreme autonomic instability 24 hours before and after beginning treatment with bromocriptine.

Seven days after beginning treatment for NMS and neurosyphilis, the patient had improved, his labile hypertension was controlled, muscle rigidity was decreased, but memory impairment persisted.

Psychological testing revealed severely impaired generalized cognitive dysfunction with deficits in immediate recall and recognition memory. The patient was transferred from the neurology ward to a rehabilitation unit after completion of his 14-day IV antibiotic treatment for neurosyphilis. He remained on bromocriptine, and dantrolene was added to maximize treatment. A single photon emission computed tomographic scan, ordered to determine brain functioning, was unremarkable.

Eventually, the bromocriptine and dantrolene were discontinued, and the patient was discharged to a nursing care facility. Although the patient was free of NMS symptoms, cognitive impairment remained.

Discussion

This case illustrates how NMS was precipitated in a patient with undiagnosed neurosyphilis when prescribed neuroleptics for treatment of psychotic symptoms and supports the theory of an organic cofactor necessary to induce NMS in patients taking neuroleptics.[2]

The undetected neurosyphilis, which can present initially as psychosis, also accounted for the cognitive and memory deficits that were irreversible. Delay in the treatment of neurosyphilis may have been avoided if a thorough organic evaluation had been initiated when this patient first presented with psychotic symptoms, including a thorough history and physical, with appropriate laboratory tests and, when warranted, radiologic tests (ie CT scan of the head) to rule out tumors, metabolic abnormalities, and infections processes that can induce psychotic symptoms.

Three important considerations bear emphasis. First, patients with initial-onset psychosis should undergo a complete organic evaluation prior to the use of antipsychotic medications. Second, physicians who prescribe neuroleptics may confront NMS, thus the primary care physician, as well as the psychiatrist, should be cognizant of NMS symptoms and treatment to abort this potentially life-threatening condition. Third, NMS may be precipitated from metabolic or other organic cofactors, a theory requiring further study.

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Special

Levels of physician responsibility in diagnosis and treatment of addiction

David G. Benzer, DO, and William Anderson, MD, Wauwatosa

Otis R. Bowen, MD, former secretary of Health and Human Services, has pointed out that "Alcoholism and other drug dependencies are among the most difficult to treat of medicine's challenges. As physicians, we have a role in the prevention and treatment of alcohol and drug related problems, and this role must be addressed now. The future of too many of our current and future patients demands that we no longer accept such losses silently."[1] Not only are they among the most challenging to treat, but they are also among the most common illnesses encountered by physicians in primary care. As many as 20% of the patients seen in ambulatory care settings are chemically dependent;[2] another 30% to 40% of patients in general hospitals also manifest the often unrecognized diagnostic signs of alcoholism or other drug dependency.[3] Physicians are usually adept at treating the medical consequences of addiction, but most tend to fall short in recognizing and treating the underlying addiction. This failure is largely due to inadequate training in diagnosis and treatment of addictions.

In contemplating their response to the challenge of chemical dependency, physicians are often uncertain of the role they should take and the extent to which they should be involved in the treatment of the alcohol or drug dependent patient. The appropriate level of responsibility one assumes must be arrived at based on one's training, combined with the availability of community addiction treatment resources. Three possible levels of physician involvement are suggested.[1]

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Level I

This level of responsibility would consist of diagnosis and referral and ideally would apply to all physicians with clinical responsibility in any area of medicine. All clinicians should be aware of medical complications, symptoms, and syndromes by which alcoholism (or drug abuse) commonly presents. Medical complications of addiction should be recognized as early as possible.

It is too common for physicians to "participate in the patient's denial," and overlook the underlying addiction that can cause various maladies, such as gastritis, insomnia, etc. Granted, the easiest thing to do is simply to prescribe a gastric acid blocker or a short acting benzodiazepine, but this serves only to enable the perpetuation of their chronic, progressive, fatal disease of addiction.

Any complete health examination should include an in-depth history of alcohol and other drug use. Amounts and frequency of consumption are important, but hallmarks of chemical dependency such as continued use in the face of negative consequences, and loss of control over consumption, should also be considered. When a problem is identified, the physician should be able to evaluate the patient requirements and community resources so that an adequate level of care can be prescribed, with referral to a resource that provides the appropriate treatment.

Clearly, the majority of physicians in clinical practice will find themselves operating at a Level I involvement in the treatment of alcoholism and other drug dependencies. This will often be the area with the greatest potential for the clinician to positively affect the patient's life--if the physician is prepared to intervene appropriately. With this in mind, further elaboration regarding Level I is in order.

Physicians must be aware of alcohol and other drug-related sequelae such as a trauma, domestic abuse, and medical and psychiatric consequences of addiction. If those occur, specific risk reduction–health maintenance efforts–should be initiated. This entails either a physician or a counselor reviewing with the patient his or her chemical using practices in light of health status, lifestyle, and activities associated with chemical use, with the goal of identifying additional risk factors and adopting a plan to reduce risks.

If uncertain as to the presence, extent, or nature of alcohol or other drug problems, the Level One physician can refer the patient for further evaluation. This is accomplished by proceeding as with any other potentially serious medical problem. Explain the need for further evaluation or consultation. Provide reassurance and hope, noting that you are making a referral to someone you and the patient can trust. Follow up on the referral to verify that the patient went for consultation. If alcohol or other drug dependency is present, treatment is required, either by the physician or through referral to a specialized treatment program or provider.

When making a referral, provide basic information to the patient. Make it explicit that people can develop problems as a consequence of alcohol or other drug abuse, including physical and emotional problems, school or work, impairment and problems in family life. Use medical authority, making it clear that these problems are a medical concern, that outside resources are necessary to treat chemical dependency, and that it is a condition potentially too serious to disregard. Inform the patient and his or her family, when possible, that chemical dependency is an illness, that the patient is not to blame for having an illness, and that

successful treatment is possible. Inform the patient and family about the available resources for help, including self-help groups such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, Adult Children of Alcoholics, Al-Anon, and Al-Ateen. Explain that you will continue to be available. In making a referral for treatment, the Level One physician should be active. Rather than just giving an agency name and phone number, the physician's office should set up a specific appointment time.

It is important that physicians be familiar with the community resources for alcoholism and drug abuse treatment and prevention before a problem arises. Call your state alcohol and drug abuse agency for a list of publicly and privately funded treatment programs in your state. Consult employee assistance programs in your area. Ask colleagues for names of programs they have found successful. Contact an addiction treatment specialist or program, mental health center or hospital for consultation.

In collaborating in care during and after addiction treatment, the referring physician can provide support and follow-up. Request a report from any treatment provider to whom you refer a patient, including specific treatment recommendations and clarification of your role in the continued care of the patient. Be prepared to reinforce with the patient and family the need for compliance. Schedule follow-up visits to monitor the patient's status and involvement in the treatment regimen such as AA attendance or counselor visits, as well as to provide needed medical care. Maintaining continuity in your relationship with the patient is crucial should the motivation and commitment of the patient to recovery falter. The physician should be better able to intervene if a therapeutic alliance has been maintained.

Level II

Level II involvement means that the physician is accepting limited treatment responsibility to restore the patient to the point of being capable of participating in a long-term treatment program for his or her addiction. All the skills needed for

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Level I are involved, as well as full knowledge of the medical management of alcoholism and drug abuse and their sequelae.

Level II initially involves assisting the patient to achieve a state free of alcohol and other drugs, including management of acute withdrawal syndromes. All associated or complicating illnesses should be recognized, treated, or referred as needed. Simultaneously, the patient can be apprised as to the nature of his or her addictive disease and the requirements of recovery. The physician and patient can then evaluate resources (medical, economic, interpersonal and social) and match them to the patients' needs to formulate an initial recovery plan. The need for involving significant others in the initial recovery plan should also be addressed.

Once the patient's condition is stabilized and available resources are identified, a long-term recovery plan can be developed with the patient's participation. Depending on the patient's situation, this might include referral to a physician specializing in addiction medicine, an AODA counselor, or 12-step self-help groups in addition to follow-up by the primary care physician.

This level of responsibility should not be assumed casually as the pitfalls are many, not the least of which is the tendency of the addict to subconsciously attempt to sabotage his or her own recovery.

Level III

Level III describes those physicians accepting responsibility for long-term treatment of addiction. The physician should be knowledgeable in the treatment of chemical dependency by training or experience. Generally, this would require specialization in addiction medicine. The following responsibilities should be conducted or supervised by the physician:

- Establish a supportive, therapeutic, and non-judgmental relationship with the patient.
- Establish specific conditions and limits under which the therapy will be conducted, and carefully explain them to the patient.
- Involve the patient with an abstinent peer group when appropriate.
- Become knowledgeable about and use various health, social, vocational, and spiritual support system resources.
- Evaluate directly or indirectly significant other persons and, unless clearly contraindicated, involve them in treatment.
- Medication needs should be continually monitored. After treatment of acute withdrawal, psychoactive drugs should be used only when there is a clear-cut and specific medical requirement.
- Throughout the course of treatment, the physician should continually monitor and treat, or refer for care, any complicating illness or illness relapse.
- Periodically the physician should evaluate and update the recovery plan with the patient's participation.

The physician providing this level of care should be available to the patient as needed for an indefinite period of recovery should any assistance be required in maintaining sobriety.

There will be occasions when all efforts to engage a patient in treatment will fail. In these instances, the physician has a responsibility to provide medical care for problems related or unrelated to substance abuse. He or she should make clear to the patient what the underlying problem is and remain ready and willing to arrange for treatment.

When possible, the primary care physician should encourage family members to enter into support systems, whether formal treatment or self-help groups (Al-Anon, Al-Ateen, etc) to minimize their distress and deal with the problems of living with the chemical dependent person. Often this helps the family to avoid enabling of the addicts' continuing using.

The physician should also take steps to avoid enabling the chemically dependent patient by not providing psychotropic medications for anxiety, insomnia, depression, etc, and by not authorizing "sick time" to cover up alcohol or drug related episodes. If a respectful, non-judgmental, and caring relationship has been maintained with the patient, the possibility for success in the next intervention will be enhanced. Remain ever alert to the next opportunity to persuade the patient to obtain needed care.

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Public health

Increasing incidence of prostate cancer in Wisconsin, 1980-1990

Elise M. Jochimsen, MD; Patrick Remington, MD; and Jerri Linn Phillips, MA, Madison

PROSTATE CANCER is the most common cancer and the second leading cause of cancer death among men in Wisconsin. It is estimated that one in 11 men will develop this disease during their lifetime. In the United States, the incidence of prostate cancer has increased substantially since 1980.[1] The reason for this increase is not known.

Methods

To determine trends in prostate cancer incidence in Wisconsin, we analyzed data from the Wisconsin Cancer Reporting System from 1980 to 1990. Incidence rates are expressed per 100,000 male population and were calculated based on the 1980 and 1990 population estimates from the US census. We used 5-year stage-specific survival estimates from SEER,[2] to estimate the effect of changes in diagnosis on mortality in the state.

Results

The overall age-adjusted incidence rate of prostate cancer in Wisconsin increased 41% between 1980 and 1990, from 75 to 106 per 100,000 male population (Figure). The incidence of prostate cancer increased for all age groups 50 and older (Table). The greatest increase is seen in men 60 to 69 years of age (62%).

During this time, the incidence of prostate cancer diagnosed at the localized and regional stages increased, while the incidence of cases diagnosed at a distant stage decreased (Table). Applying national stage-specific survival rates (84%, 73%, and 29% for local, regional, and distant stages, respectively), to the cohorts of men diagnosed in each year, suggests that overall 5-year survival rates would be expected to increase from 72% to 75%. Given the substantial increase in the number of men diagnosed by 1990, however, the overall 5-year mortality rate would be expected to increase from 49 to 75/100,000.

Comment

Nationally, the incidence of prostate cancer has increased steadily since the 1950s.[1] Because the etiology of prostate cancer is not clearly understood, it is possible that

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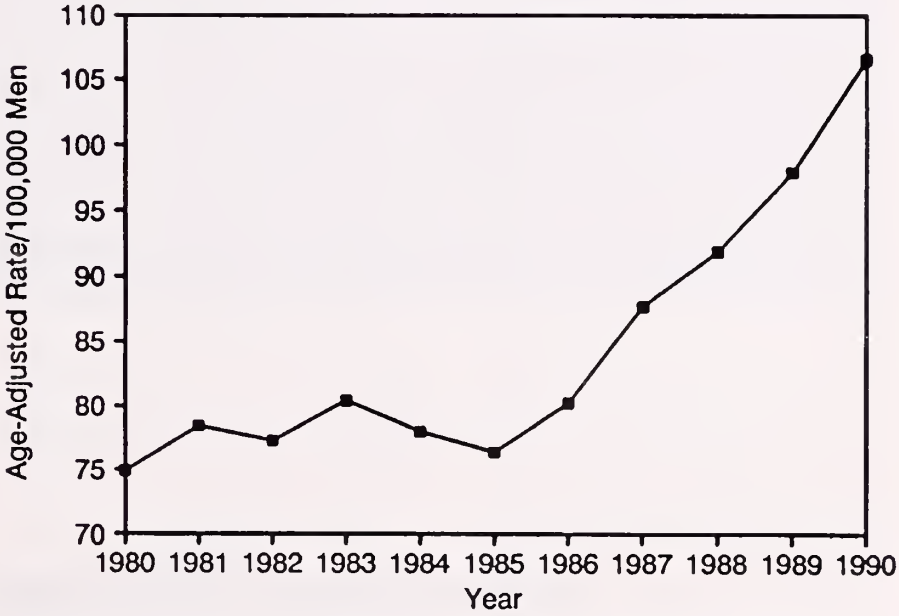

Fig.–Trends in prostate cancer incidence in Wisconsin, 1980-1990. Age-adjusted to the 1970 US Census.

The public health column is not reviewed by the *WMJ* Editorial Board. Jochimsen was a fourth-year medical student on elective at the Wisconsin Division of Health. Dr Remington is the state chronic disease epidemiologist in the Bureau of Public Health, Wisconsin Division of Health, and coordinator of the public health series for the *WMJ*. Phillips is the lead analyst for the Wisconsin Cancer Reporting System, Center for Health Statistics. Address reprint requests to Patrick L. Remington, MD, Wisconsin Division of Health, 1400 E Washington Ave, Madison, WI 53703-3041. Copyright 1992 by the State Medical Society of Wisconsin.

Continued from preceding page
increases in certain behavioral or environmental risk factors have resulted in an increase in incidence on prostate cancer. Others have suggested that the rise in prostate cancer incidence has been caused by an increased use of transurethral resection of the prostate (TURP) to relieve urinary obstruction, commonly associated with benign prostatic hypertrophy.[3,4]

There has been little discussion about the factors responsible for the dramatic increase in incidence that has been observed since 1985. It is unlikely that changes in risk factors could account for such an abrupt change. In addition, rates of TURP have not increased, and, in Wisconsin, have actually decreased during this time (Wisconsin Division of Health, unpublished data).

A potential explanation for the recent increase in incidence is the increasing use of prostate-specific antigen (PSA) testing. PSA is a sensitive serum marker which was approved by the FDA in 1985 for monitoring the progression of prostate cancer and the response to therapy. Recently, PSA has been promoted as a tool for mass screening for prostate cancer,[5] and routine screening is becoming a standard practice in some areas.

If prostate cancer is being detected at an earlier, more treatable stage, one would eventually expect to see a decline in the mortality rate for the disease. This has not been the case. In Wisconsin between 1980 and 1990, the age-adjusted mortality rate for prostate cancer increased 29%, from 22 to 28 per 100,000. Mortality rates for prostate cancer in the United States over the same period have also increased.[1]

It has been suggested that the increased prostate cancer mortality rates are due to declining competitiveness of ischemic heart disease and stroke as causes of death in older age groups.[6] Nevertheless, there is some concern that deaths due to prostate cancer have not decreased--despite refinements in operative, radiotherapeutic, and endocrinologic treatment--because the disease is too often diagnosed after it is no longer confined to the prostate.

Trends in the incidence rates of prostate cancer in Wisconsin per 100,000 male population by age and stage at diagnosis, 1980-1990.

	1980	1990	Relative change
Total*	75 (1748)	106 (2808)	1.4
Age			
50-59	39 (87)	60 (124)	1.5
60-69	264 (479)	428 (815)	1.6
70-79	687 (730)	1030 (1266)	1.5
80+	1039 (448)	1122 (585)	1.1
Stage*			
Localized	47 (1092)	69 (1815)	1.5
Regional	7.1 (166)	18 (472)	2.5
Distant	15 (354)	12 (323)	.8

*Age-adjusted to the 1970 US census. Unknown stage excluded. ( ) Number of cases.

The main goal of a cancer screening program is to improve survival and decrease mortality. To date, it has been shown that screening for prostate cancer can increase early detection, but there is no experimental evidence that screening reduces mortality. Because only a fraction of patients with prostate cancer die from it, screening may in fact diagnose tumors that, left undetected, would not become symptomatic. Thus, patients may be treated unnecessarily, resulting in significant morbidity, mortality, and expense.[7,8]

Currently, there is no clear consensus regarding prostate cancer screening. The American Cancer Society and the National Cancer Institute recommend annual digital rectal examination for prostate and colorectal cancer screening beginning at age 40. The American Urological Association and the American College of Radiology recommend annual PSA screening for all men over age 50. The US Preventive Services Task Force believes that there is insufficient evidence to recommend for or against routine digital rectal examination as an effective screening test for prostate cancer; transrectal ultrasound and PSA are not recommended for routine screening.

Clearly, the issue of prostate cancer screening is an important one which deserves further attention and study. Specifically, careful controlled trials are needed to determine whether screening programs using digital rectal exam, PSA, or transrectal ultrasound can save lives.

Acknowledgments

The authors thank Reginald Bruskewitz, MD, Paula Lantz, PhD, and Gianfranco Pezzino, MD, for their helpful comments.

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After the meltdown

Mobile clinic brings care to Ukraine

Shari Hamilton, assistant editor

For generations, the Ukrainian people have related a fable that tells how one day eagles will soar down and save their country from its many troubles. After years of dominance by the Poles, Russia, the Nazis and lastly, the Soviet Union as well as the world's worst nuclear nightmare, the eagles have finally landed, according to one Ukrainian official, and their names are Stephen and Lusia Dudiak, of the Medical Clinic on Wheels.

In April, the SMS House of Delegates endorsed the Medical Clinic on Wheels, a humanitarian health care project providing medical care to the people of northern Ukraine. That endorsement came at the request of Madison radiologist Stephen Dudiak, MD, the driving force behind a campaign to deliver quality health care to the children exposed to the April 26, 1986, meltdown of the Chernobyl nuclear facility.

If anyone had asked Dr Dudiak a few years ago how he would spend his golden retirement years, he would probably have quietly shared his plans for working in his garden or home workshop. Those modest projects may never come to be. The would-be home putter has become a frequent globe traveler. As medical director, he can usually be found seeking support for the Medical Clinic on Wheels, arranging transportation or accompanying volunteers and supplies to Ternopil, a city in northern Ukraine.

Ukranian physicians engaged in a lengthy question-and-answer period after three American and one Canadian doctors lectured on western medical practices at the Medical Institute in Ternopil. *Photo by Bob Rashid.*

A native of Ukraine, Dr Dudiak spent 32 years as a practicing radiologist in Madison and is a former chief of staff at St Mary's Hospital. When the disastrous nuclear accident occurred in his homeland, Dr Dudiak took a special interest in learning about the Chernobyl nuclear accident. The radiologist perused all the articles he could find tracking effects of the disaster on the health of residents of the northern Ukraine–particularly young children. But in many cases, his search came up short; little information was being collected, few articles were published. Under the strict restraints of Soviet control, the disaster was played down. Scientists were barred from the region, prohibited from compiling data, conducting tests, or studying the disaster.

According to Dr Dudiak, years of government suppression of information sur-

The Medical Clinic on Wheels is loaded on a Russian military transport AH-124 in Milwaukee. Photo by Bruce Herrick.

Continued from preceding page

rounding the catastrophe and the delay in reporting of the accident caused much valuable information to be lost forever. "This is the worst tragedy in civilization. We don't know what damage has been done genetically. They were so concerned to cover it up that they didn't get statistics and research for humanity and the future," said Dr Dudiak, deeply disturbed by the short-sighted government response and apparent disregard for the reality that the Chernobyl disaster could be repeated at any of the more than 10 nuclear facilities in the Ukraine and Russia based on the same design.

As part of the Soviet Union, Dr Dudiak said Ukraine was helpless, totally lacking in the vital resources needed to respond to the crisis. In April 1991, he approached the minister of health for the Ukraine and requested permission to bring mobile health clinics to the accident area. The government official was very receptive and enthusiastic about the potential for children to receive much needed health care.

The health minister was particularly concerned, Dr Dudiak said, about the lack of dental care for his citizens. Dr Dudiak estimates that the Ukraine is about 23 years behind the United States in dental technology and access to dentistry in nonexistent in most parts of the Ukraine. As a result, he said, very young children lose their permanent teeth and all to soon become the bearers of ill-fitting false teeth.

On his return to Madison, Dr Dudiak rallied others to join him in the outreach effort. With the Rev John Shep, of the Stoughton-based Lutheran mission, "Thoughts of Faith," and other concerned individuals, Dr Dudiak organized the international initiative.

The Medical Clinic on Wheels is firmly grounded in the "teach a man to fish" philosophy. It was not enough for health care professionals to go to the Ukraine and treat patients there, Dr Dudiak explained, Ukraine physicians need opportunities to learn new technology, to open the doors closed to them during communist rule. It also makes no sense for Ukrainian physicians to travel to the United States to observe American physicians because they would be prohibited by law from touching patients. But if physicians from Wisconsin and other states travel to the Ukraine, they can share their knowledge directly with physicians there on a one-to-one basis or in group settings, and help physicians integrate this new knowledge into their medical practice.

A grant from Schwan's Sales Enterprises, Inc, of Minneapolis, funded construction of two specially-equipped mobile homes, constructed by Midwest Mobile Technologies, Inc, of Ohio. One vehicle features two dental chairs so a volunteer American dentist and a Ukrainian dentist can work side-by-side. The dentists discuss their findings as they examine patieints, then rotate patients so the Ukrainian dentist can learn new techniques, Dr Dudiak explained.

The second van has been transformed into a health care clinic with two examining rooms and a small laboratory. This van travels throughout the countryside, bringing health care to pregnant women and children.

The Medical Clinic on Wheels has established its base at a tertiary care hospital in Ternopil (a city about the size of Madison located near the Polish border), setting up a stationary clinic and pharmacy at this locale, Dr Dudiak said.

Through these three clinics, health care workers are beginning to address the many needs resulting from the Chernobyl accident as well as combat the effects of pollution and poor nutrition. Fruits and vegetables are often in short supply and parents are afraid to give milk to their

Continued on page 544

A nurse anesthetist from Madison (l) explains to the Ukranian director of anesthesia (c) the problems he is having communicating western methods. Photo by Bob Rashid.

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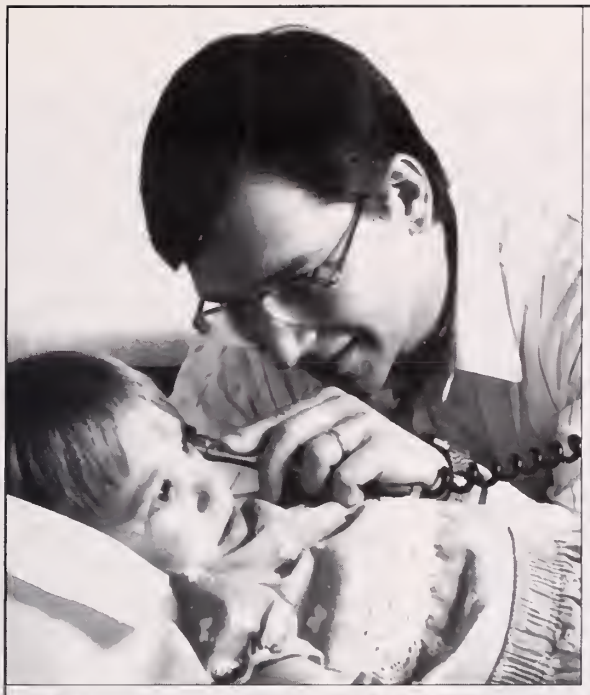

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Continued from page 542
children due to the possibility of radiation leakage.

From April to early August, the Medical Clinic on Wheels treated 1,500 patients. Although at first glance many children look as healthy as their American counterparts, anemia is common, Dr Dudiak said, and 6 years after radiation exposure, the number of cases of leukemia and other malignancies have increased dramatically.

Birth defects are also a concern. Dr Dudiak said many young women do not want to have children after witnessing birth defects within their families and the animal population of the region. Unbelieveably, some people still reside within contaminated areas, not fully understanding the risks, Dr Dudiak said.

A trip to a Ukrainian hospital is like a trip back in time for American medical workers. Many operating rooms resemble the ones seen in the United States in the 1950s. Until the Ohmeda corporation, of Madison, donated anesthesia machines to the Medical Clinic on Wheels, the Children's Hospital in Ternopil had only the option of using intravenous drugs to anesthetize patients for surgery. Although in large cities like Kiev, there are hospitals as well equipped as those in the West, those facilities are an anomaly, built to meet the health care needs of prominent Soviet officials. Rural hospitals have no laboratories, and even the most ordinary of items–blood pressure cuffs, thermometers and IV tubing–are nonexistent, according to Rosemary Bercham, RN, a nurse from St. Mary's Hospital in Madison who made the trip to Ternopil in June.

Physicians in the Ukraine are well trained, Dr Dudiak said, but hampered by severe shortages of medicine (even aspirin is in short supply) and a void of diagnostic technology. Bercham told of a young girl carried into a clinic by her parents, wheezing and struggling for every breath. When the girl was given an inhaler brought in by the Medical Clinic on Wheels, "her eyes got just like saucers. She thought it was a miracle that she could be able to breathe with just one push on the inhaler button," Bercham said.

Incentives for physicians are few; doctors earn smaller salaries than school teachers, bringing home the equivalent of $20 per month. Hospital administrators face another quandary, Bercham said, as a layover from the communist regime, personnel are not fired. Once an employee is hired to work in the hospital, regardless of performance, tradition says the post is for life.

When the Medical Clinic on Wheels first arrived in northern Ukraine, Dr Dudiak said physicians there–accustomed to beginning work between 9 and 10 am and taking weekends off–had difficulty

Rosemary Bercham, a nurse with St. Mary's Hospital in Madison, has fun teaching Ukranian children how to say "Madison, Wisconsin."
Photo by Bob Rashid.

understanding the American drive to begin work early in the morning and see patients 7 days per week. Now that these doctors have more resources to work with and have seen they can make a real difference in patients' lives, they are among the first to arrive in the morning, Dr Dudiak said. The Medical Clinic on Wheels also donated more than 1,000 medical books and video tapes to the medical school in Ternopil, giving the students, Dr Dudiak said, tremendous incentive to study the English language and opening a "window to the West."

Traditionally, the doctor-patient relationship in Ukraine has been strained, but after observing how American physicians interact with their patients, Dr Dudiak said some Ukrainian physicians are learning to soften their approach and treat patients more compassionately.

In addition to the SMS which has encouraged physicians to lend their support to the Medical Clinic on Wheels, several other entities have backed the international health care effort. The Acuson Corporation recently donated a new state-of-the-art ultrasonography unit to aid in obstetrics care. The Ohmeda Corporation, of Madison, donated five anesthesia machines, a baby warmer, and multiple accessories while numerous hospitals (St Anthony Hospital in Oklahoma City, St Mary's in Madison, Froedert in Milwaukee and St Clare Hospital in Baraboo) have donated more than 1,000 new and used surgical instruments, and operating room, pediatric, obstetrical and laboratory supplies. The wish list still includes: pediatric medicines, vitamins, neonatal supplies, incubators, pediatric surgical instruments and supplies, instruments and supplies for OB/GYN practice, adult surgical instruments and supplies, recent medical books and journals.

Dr Stephen Dudiak, of Madison (r) the medical director of Medical Clinic on Wheels, receives expressions of gratitude from an Ukranian associate professor of internal medicine (l). In addition to bringing western health care, Dr Dudiak brought a donation of more than 1,000 medical texts for the Medical Institute in Ternopil. Photo by Bob Rashid.

An American doctor (c) and Ukranian doctor (l) examine a Ukranian girl in the Medical Clinic on Wheels. A Canadian translater (r) looks on. Photo by Bob Rashid.

Dr Dudiak said the Medical Clinic on Wheels has been able to maintain total control over shipments so there is virtually no possibility for damage or theft. His wife, Luisa, takes an active role in the project and assumes much responsibility for ensuring supplies are delivered and distributed as planned. As no parts are available for repairs, Dr Dudiak said all donated equipment must be new or in perfect condition to be a real asset.

Those who have traveled to the Ukraine to see the project in action attest to the strength of Dr Dudiak's commitment and the value of the humanitarian effort. Wrote Ohmeda manager Gregory L. Welyczko, "My colleague and I traveled to the city of Ternopil to set up the donated equipment. To look at the faces of the

Continued on next page

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people, full of expressions of heartfelt gratitude for his (Dr Dudiak's) care and his presence with them (in the area where the levels of radiation are still in question), is to be awarded for his unselfish and enduring efforts to make our world a better place to live for less fortunate people and their suffering children."

Although she had only a vague idea where the Ukraine was located when she first got involved, Bercham, a long-time colleague of Dr Dudiak, was recruited to help gather donations. She accompanied more than 40 boxes of medical equipment to the Ukraine. Bercham, who has a clinical background in emergency medicine and surgery, said the trip was "the experience of a lifetime." She delighted in her visits with people eager to explore their newfound freedoms and quick to question visitors about Western life. She was charmed by the children and the beauty of the Ukraine's historic structures and countryside.

Bercham found the transition to Ukrainian life was easily made. Communication was aided by an interpreter, the Americans drank bottled water and the air was fresh and clean, she said.

The Ukrainians love their country and are thankful that Americans are helping them get on their feet, Bercham said, relating the story of how one Ukrainian official stood during a gathering to recognize the program, likening the Dudiaks to the fabled eagles who rescued the country.

The eagles may have arrived in northern Ukraine, but their work is not done. If you are interested in supporting the Medical Clinic on Wheels or want to volunteer, write to: Stephen Dudiak, MD, Medical Director, Medical Clinic on Wheels, 7029 Applewood Dr, Madison, WI 53719, or telephone (608) 833-1953.

Pediatricians, family physicians and obstetricians are particularly needed to care for children and pregnant women in the region, but Dr Dudiak said physicians in all specialties will be welcomed to teach and see patients at the stationary clinic. The Medical Clinic on Wheels provides room and board to volunteer physicians, but volunteers are asked to shoulder their own travel expenses. Special arrangements may be made, Dr Dudiak said, to help young physicians afford travel to the Ukraine.[15th]

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From municipal hospital to medical center: Milwaukee County General Hospital, 1965-1980

Jonathan W. Friedberg, Milwaukee and Boston

In the early 1960s, Milwaukee County General Hospital towered above the other institutions on the Milwaukee County grounds, surrounded by lagoons, trees, and acres of wooded land. The main hospital building's Victorian style, its broad columns holding up the ivy covered entrance, was symbolic of the paternalistic yet compassionate mission of the sole hospital in Milwaukee County dedicated to the treatment of the poor. The busy municipal hospital was growing in size; a new 550-bed patient care facility had been recently constructed behind the main building. County General was a successful institution, with a reputation for providing quality care in a modern, efficient setting due in large part to broad, continued support of a progressive community interested in its less fortunate population.

Milwaukee County General Hospital. Photo by Jonathan Friedberg.

Wisconsin physicians have fond memories of Milwaukee County General Hospital during the early 1960s. Dr John Petersen, director of Medical Services at County General since 1966, described the hospital.[1] "[It had] many more patients than hospitals have today. [There were] open wards, with 14 to 16 beds lined up one after the other." The hospital was indeed the largest in Milwaukee at that time, admitting more than 25,000 patients in 1965 and seeing 189,000 patients in outpatient facilities. That year, almost 2,000 babies were delivered in the hospital.[2]

Dr Gerald Kerrigan, a pediatrician at County General in the early 1960s and later appointed dean of the Medical College of Wisconsin, compared County General to other large municipal hospitals of the era, explaining that, "problems of Milwaukee compared to Chicago and New York were minuscule, particularly at that time.... The hospital, by contrast with other [municipal] hospitals in the nation was a pleasant place to be." County government did not become overly involved in everyday hospital affairs, allowing the hospital to accomplish its mission without the political undertones of patronage hiring and corruption. The unionized county civil service employees at the hospital were often cited as being "parental," yet their dedication to patient care was not questioned.

Commenting on the strengths of the hospital in the early 1960s, one administrator recalled, "We were one of maybe two emergency services in town. We started with a downtown unit–a 50 bed hospital with operating rooms." The county emergency and outpatient hospital, located on the west side of Milwaukee, was a vital health care link to the population living in the downtown area, open 24 hours daily, and staffed by physicians. Ambulances shuttled patients from the Milwaukee unit to the general hospital facility in Wauwatosa if inpatient treatment was necessary.

County General was the forerunner in Milwaukee of many medical breakthroughs, including open heart surgery, renal dialysis, renal transplant and megavolt irradiation. It served as the main teaching facility for the Marquette University Medical School, and according to Dr Kerrigan, "It had a good residency staff; there were competent people supervising the residents." Its residency positions were filled yearly, and physicians agreed that it was the best equipped hospital in the city at that time.

Like other municipal hospitals of the day, County General was primarily financed through the county tax levy with some contribution from the state government. Private patients and those with health insurance were not allowed admis-

Continued on next page

Friedberg is a Milwaukee resident and third-year medical student at the Harvard Medical School in Boston. Reprint requests to: Jonathan W. Friedberg, 107 Ave Louis Pasteur #170, Boston, MA 02115. Copyright 1992 by the State Medical Society of Wisconsin.

Continued from preceding page
sion to the hospital except in cases of emergency. Characteristically, before 1965, the hospital did not have any billing mechanisms, and did not charge for inpatient care. Physicians, on a volunteer basis, saw thousands of outpatients in the crowded, noisy clinics, which provided more than half of all ambulatory services to the people of Milwaukee County. The full-time hospital staff consisted of a small number of salaried Marquette University Medical School faculty.

Situated in Wauwatosa, 8 miles west of downtown Milwaukee, the quiet, park-like setting of the Milwaukee County Institutions Grounds seemed far removed from the impending turmoil of the late 1960s that was to transform and, in many cases, eliminate municipal hospitals across the country.

The period from 1965 to 1980 was one of transition for County General. In response to federal initiatives for health care financing and Milwaukee business leaders who actively initiated change to the city health delivery system, County General emerged to become the County Medical Complex of today.

With the implementation of Medicare and Medicaid legislation by the federal government, many poor and elderly patients had the financial choice to seek care in voluntary institutions. These hospitals, projecting a reliable stream of income from the federal government, and recognizing a huge market potential, began expanding and offering comprehensive health services to the Medicare and Medicaid population. Milwaukee County General Hospital had to begin competing with the voluntary institutions in the city for its patient base.

It took time for the municipal hospital to appreciate the ramifications of the federal programs, and County General lost patients during this transitional era. The pediatrics department, once 86 beds, was forced to close as increasing numbers of its former patients sought care at Milwaukee Children's Hospital (now Children's Hospital of Wisconsin). The obstetrical service scattered to many community hospitals, especially Mt Sinai Hospital (now Sinai-Samaritan Medical Center) downtown, and St Joseph's Hospital on the north side of Milwaukee. For many patients, these other hospitals were more convenient than County General, which was far from their homes.

County General began to respond. In 1967, the county board approved a plan to collect fees at County General Hospital, permitting admission of patients with private insurance to the hospital for the first time. This allowed County General to compete for the same patients as voluntary facilities, and at the same time raise needed revenue. The County Board of Supervisors began to play a much more significant role in hospital affairs than in previous years. To its credit, unlike the experience seen in many other large urban centers, the county board continued to support the hospital fiscally. Only St Louis and New York City spent as large a share of local government expenditures on health and hospital activities as Milwaukee County did in 1972, according to a study of the 40 largest cities in the United States.[3]

The County Health Committee, under the leadership of County Supervisor Terrance Pitts, acted as a governing board of directors for the hospital which still maintained its public responsibility, providing care for all county residents regardless of ability to pay.

Much had to be done to make County General a viable alternative to newer voluntary facilities in town. An administrator described the process of "rectifying the creature comforts, including [adding] the three 'T' of treatment: telephone, toilets and television." Millions of dollars were spent breaking up the old wards and creating private and semiprivate rooms; the last of the 16-bed wards closed in 1976.

County General, with its long-held tradition of cross-charging, favoring the use of county-run departments over private enterprise for services such as laundry and security, found its rather bureaucratic system in conflict with the competitive environment. The county struggled to install its first billing system, which proved to be a difficult endeavor. Efficiency and patient relations among the civil service work force were emphasized to increase patient satisfaction. The downtown emergency and outpatient hospital was abandoned due to a debilitated physical plant; these services were centralized and streamlined in the Wauwatosa general facility.

Still, despite these positive efforts, the tumultuous health care environment forced many political and business leaders in Milwaukee to examine County General and determine whether it still served a public purpose. A perceived physician shortage highlighted the importance of continuing the clinical program of Marquette University Medical School, which was primarily at County General.

In this context, and responding to federal funding initiatives, John Doyne, the county executive, saw the opportunity to pursue a lifelong dream of creating a great medical center on the county

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grounds in Wauwatosa. He fostered public-private cooperation as the way to his dream, and became an ally of the Greater Milwaukee Committee, a group of influential business leaders, who supported regional medical center construction, and creation of a tertiary care referral center at Milwaukee County General.

Clearly, the formation of the Regional Medical Center and the building of Froedtert Memorial Lutheran Hospital, a voluntary facility affiliated with the medical school, had major ramifications on the County Hospital. County General became a major referral tertiary care center in the region. Even the name of the hospital changed. County General became the Milwaukee County Medical Complex, signifying its position as the hub of an expanding medical center.

No longer nestled between trees, the County Medical Complex today is somewhat overshadowed by the legacies of the 1970s. A regional eye institute was build as part of County General in 1976. Marquette University severed ties with the medical school, and the independent Medical College of Wisconsin moved to its new facility on the County Institutions Grounds in 1978. Curative Rehabilitation Center and the Blood Center of Southeastern Wisconsin are also nearby. Froedtert, completed in 1980, physically connected to the County Medical Complex, is located about one city block away. And the Children's Hospital of Wisconsin relocated from its downtown facility to a new hospital on the County Institutions Grounds in 1989.

The three hospitals are joined by a common emergency room, and a glassed-in shared services facility housing ambulatory care departments. The sleek facade of the Froedtert building charts the Milwaukee Regional Medical Center's development and growing reputation for acute, tertiary patient care. Nevertheless, County General's old 1930 building still stands, its rich history providing a foundation for the future. The challenge will be to maintain the strong values behind the columns and Victorian architecture, as the County Medical Complex further defines its identity in the modern medical system.

Acknowledgements

The author is indebted to Patricia McArdle, EdD, for assistance in preparation and critical review of the manuscript.

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A glimpse into our past

Richard D. Sautter, MD, medical editor

15 years ago

And some folks still don't understand. A British housewife, who had suffered cholelithiasis for 18 months and was told by Great Britain's national health service that she'd have to wait a year for her operation, climbed into a hospital bed and refused to move until she had her operation. Twenty years earlier, a group of Wisconsin surgeons toured the national health systems in Denmark, Sweden and Norway and found "horrendous backlogs." The minimum wait for a cholecystectomy, for instance, was 18 months, during which additional related problems arose–problems that doubled and tripled the convalescence time. I believe it is foolish to think that the American public would tolerate such treatment.

30 years ago

How things have changed! The SMS warned school officials and the news media statewide about a hypnotist who had scheduled programs at several Wisconsin high schools. The hypnotist was going to entertain the school children by demonstrating the effect of hypnosis on student volunteers. "Hypnosis is not a game," wrote the SMS. "It is a serious scientific aid for diagnosis and treatment and should be used accordingly." Now that our school children are threatened by crack, ice, guns and AIDS, I think we can be forgiven for waxing nostalgic about the days when we worried about hypnosis.

45 years ago

Today, they'd advertise in the tabloids. A bill was introduced in the Wisconsin Legislature to license "naturopathic" doctors, a group of people the *WMJ* called a "cult." Meanwhile, a naturopathic diploma mill in Tennessee, which had been selling false credentials to people who wanted to present themselves as doctors, was raided by law enforcement officials, and a Milwaukee naturopath was fined $100 when he pleaded guilty to practicing medicine without a license. Across the state and farther north, the "plaster doctor" returned to Turtle Lake. The plaster doctor has gone to Austria in 1922 after facing several malpractice suits and being "constantly at swords-points" with organized medicine, which "sought to prevent him from practicing his healing work." Upon his return, he remarked that if he could find the ingredients to make his "famous plaster, he may start the healing art again."

60 years ago

Feed a cold and starve a cancer? The *WMJ* published an article that asserted that cancer was better prevented than treated, and that proper diet and exercise had the highest

Continued on next page

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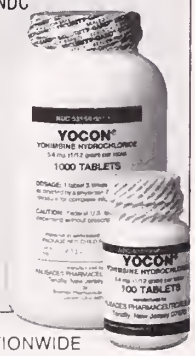

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"prophylactic value." The theory was that "over feeding" formed a toxin in the colon that, in turn, caused "excessive and uncontrolled epithelial cell proliferation." The treatment of cancer was: "well planned efforts to build up the muscular system ... and the avoidance of excessive nutrition." The article was right–cancers are nest prevented and diet has a large role to play–but for the wrong reasons.

75 years ago
Them's fightin' words. In support of the WWI effort, the *WMJ* published an article on personal military hygiene, including a section on food which cautioned that "Soldiers are much like children in the matter of over indulgence in green fruits, candies and pastries. They must be treated very much like children in regard to this matter." That's not something I'd quickly say about a man who is armed and primed to fight.

90 years ago
A dollar doesn't go as far as it used to. The total budget for the SMS in 1902 was $3,578.07. The entire annual meeting cost $283.80, with $140 of that going to the stenographer recording the transactions of the House of Delegates. Both the secretary and the treasurer earned annual salaries of $100 (although both were also full-time physicians). An attorney was retained for the entire year for $100, and a lobbyist for $125–what many of them now charge by the hour. It cost each doctor $5 a year to belong to the SMS, but this was when many in the profession were still taking farm produce as payment for services.

105 years ago
The birth of scientific medicine. Addressing the SMS House of Delegates, Dr J.M. Dodson expressed gratitude and offered praise for the "inception" of the "germ theory." He noted that "It is, perhaps, the first real, genuine scientific thing on which we can pin our faith as a basis for the structure of the science of medicine. It is something we can know absolutely.... There is a great deal of anxiety in the daily practice of medicine, for we are not very sure of not being disappointed in the action of remedies. It tends to make a man a skeptic...

120 years ago
Better than sending a fruit cake, I guess. Dr H.T. Godfrey sent a letter to the SMS Hose of Delegates, apologizing for not being able to attend the annual meeting. Although he feared that his "contributions will not be very interesting to the Society," he enclosed with his letter a diseased kidney and bladder, as well as a pig with two bodies and only one head, "as evidence of (his) interest in its welfare and prosperity." A short paper accompanied the human organs, describing a patient's slow and agonizing death and the physician's frustration in trying every remedy at his disposal but providing no cure and little relief. Dr Godfrey said he thought the patient had died from disease of the prostate, but that examination was not possible because the prostate had been "mislaid" after removal. No explanation was offered for the two-bodied pig.[150th]

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Physician briefs

Daniel Albert, MD, is the new chair of the University of Wisconsin Medical School department of ophthalmology. Lured from Harvard Medical School, where he had been on faculty since 1976, Dr Albert specializes in treatment of eye tumors.

Jodelle L. Bentley, MD,* an OB-GYN, has joined the medical staff at Rhinelander Medical Center, SC. Dr Bentley earned her medical degree from the University of Florida-Gainesville in 1979. Board certified, she completed her residency at Medical Center Hospital in San Antonio, Texas, in 1983 and practiced in Texas until 1985 when she relocated to the Monroe Clinic.

Tracy L. Bretl, DO,* has opened a specialty practice in osteopathic manipulative medicine in Saukville. Dr Bretl earned her degree from the University of Osteopathic Medicine and Health Sciences in Des Moines, Iowa, in 1989. She served as general medical officer aboard the USS Emory S. Land in Virginia until June 1992.

Frank C. Bonebrake, MD,* pulmonary and critical care specialist at Dean Medical Center in Madison, has received a 1992 Outstanding Clinical Teacher Award from the UW Family Practice Residency at St Mary's Hospital. Dr Bonebrake joined Dean Medical Center in July 1991.

Burton D. Cox, DO,* has joined the Family Medical Center of Wauwatosa. Dr Cox is a general practice physician who specializes in osteopathic manipulation and family medicine. He graduated from the University of Health Sciences College of Osteopathic Medicine, Kansas City, Mo, and completed his family practice residency at Grandview Hospital in Dayton, Ohio. Dr Cox practiced in Liberty, Me, and rural Kansas.

Rusty Exner, MD, has joined the Menominee Tribal Clinic. A family physician, the Pennsylvania native, is a 1983 graduate of Marshall University School of Medicine, Huntington, WVa.

Terrence W. Frank, MD,* has joined the practice of **Roy J. Dunlop II, MD,** working in both Stevens Point and Wisconsin Rapids. Board certified, Dr Frank is a former assistant professor of head and neck surgery at his alma mater, the University of Wisconsin Medical School.

Continued on next page

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Larry A. Hooper, MD,* a family physician, has joined Tomahawk Medical Center. Dr Hooper earned his medical degree at Wayne State University in Detroit and completed his family practice residency at Marquette General Hospital in Michigan. He has been serving in the US Navy at White Clinic Naval Hospital in Newport, RI.

Robert Van Howe, MD,* has joined the medical staff at the Marshfield Clinic-Lakeland Center. Prior to the move, Dr Van Howe practiced general pediatrics at Marinette-Menominee Clinc Ltd. He earned his medical degree at Loyola University's Stritch College of Medicine in Maywood, Ill, and served his residency at Children's Hospital of Wisconsin in Milwaukee.

Charlene Karls, DO,* Alfredo Mendoza, MD,* James Moran, MD,* and **Sandra Billingsley, MD,*** have joined the Burlington Clinic in Twin Lakes. All of the physicians will be on the staff of Memorial Hospital, Burlington.

Allen D. Kemp, MD,* has been elected chair of Dean Medical Center's board of directors. Other officers elected are: **Charles H. Diggs, MD,*** vice chair; and **David G. DeCock, MD,*** secretary-treasurer.

Muhammad Y. Khan, MD, has joined the medical staff at Watertown Memorial Hospital, specializing in general, vascular and laparoscopic surgery. Dr Khan, certified by the American Board of Surgery and a fellow of the American College of Surgeons, has been an active member of the medical staff at Sinai-Samaritan Hospital in Milwaukee since 1975.

Daniel W. Knoedler, MD,* is a new member of the Sheboygan Clinic. Dr Knoedler, a psychiatrist, received his medical degree from the University of Minnesota in 1985 and completed a residency in Ohio in 1989. Dr Knoedler most recently practiced at Scott Air Force Base Medical Center in Illinois.

Theodore A. Kotchen, MD, has been appointed professor and chair of the department of medicine at the Medical College of Wisconsin and will serve as chief of medicine at MCW's major teaching affiliates. Dr Kotchen comes to MCW from West Virginia University, where he served as chair of the department of medicine and as a professor of medicine and physiology. Dr Kotchen has published extensively in peer-reviewed journals. His research focuses on mechanisms and treatment of high blood pressure.

Jeffrey A. Kurtz, MD,* a board-certified plastic surgeon, has joined the medical

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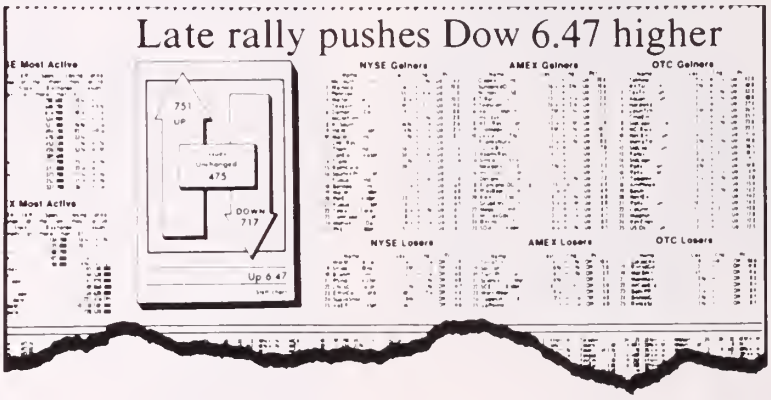

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staff of Memorial Hospital of Taylor County. Dr Kurtz earned his medical degree and served his internship and residency at the University of Wisconsin.

Perry L. Kyser, MD,* recently joined the medical staff of Midelfort Clinic in Eau Claire. Dr Kyser received his medical degree from Ohio State University College of Medicine and interned at Fitzsimmons Army Medical Center in Denver. He completed his radiology residency at Brooke Army Medical Center at Fort Sam Houston, Texas. Most recently, Dr Kyser was chief for the areas of diagnostic radiology, gastrointestinal radiology and emergency radiology for Brooke Army Medical Center.

W. Craig Leach, DO, of Wauwatosa, has been voted "outstanding teacher" by the pediatric residents at Children's Hospital of Wisconsin for the fifth time in 6 years. Dr Leach, a pediatric specialist on staff for 9 years at Children's Hospital of Wisconsin, was honored for his work in helping residents improve their clinical skills. The award has been presented to instructing physicians since 1984.

Yungho Lee, MD, a gastroenterologist, recently joined the Janesville Medical Center. Dr Lee earned his medical degree from New York Medical College and completed a fellowship in gastroenterology at Nassau County Medical Center in East Meadow, NY, and a residency in internal medicine at the University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School.

Anne Lipinski, MD, and Robert Stumpf, MD,* both of Mequon, have joined the Cedar Mills Medical Group, located in St Mary's Health Center, Cedarburg. Dr Lipinski holds a medical degree from Michigan State University and completed an obstetrics-gynecology residency at St Mary's Hospital in Milwaukee. Dr Stumpf, also an OB-GYN, received his medical degree from the Medical College of Wisconsin and served his residency at St Mary's. Both physicians were co-chief residents at St Mary's and are junior fellows of the American College of Obstetricians and Gynecologists.

Mark D. Lupton, MD,* a neurologist, has joined the staff of the Janesville Medical Center. Dr Lupton has provided medical care for the past 13 years at two Chicago-area hospitals. He earned his degree from the University of Illinois College of medicine in Chicago. He completed his internship and residency at Michael Reese Hospital in Chicago.

Paul Madsen, MD,* a Madison urologist, learned recently that Denmark's Queen

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Margrethe II has made him a knight. Dr Madsen, a Denmark native, earned his medical degree from the University of Copenhagen in 1952 and came to America on a Fulbright Fellowship. He served as chief of the Urology Department at the Middleton Veterans Hospital and as a UW Medical School professor for 30 years prior to his retirement in 1990. Dr Madsen said he believes he received the honor because he trained numerous Danish doctors during his tenure at UW. He also initiated a teaching course in surgery at the University of Copenhagen.

Robert Nagle, DO, began practicing in Waupan on Aug 3. Dr Nagle is a family practice and obstetrics physician. He earned his medical degree from the University of Osteopathic Medicine and Health Sciences in Des Moines. He interned at the Chicago Osteopathic Hospital Systems and is certified by the American College of Family Practice.

Thomas R. Perry, MD,* has joined the Monroe Clinic and St Clare Hospital. Dr Perry, a Wisconsin native, earned his medical degree at the University of Wisconsin in 1978. He completed a residency in neurology at Indiana University and served as a flight surgeon with the US Air Force.

Stephen Peterson, MD, a board-certified family physician has joined the Superior Clinic Ltd staff. Dr Peterson completed his medical training at the University of Minnesota and a residency in South Dakota.

Joseph Schwartz, MD,* recently of Darlington, will join the emergency medicine group in West Bend. Schwartz is a new graduate of the University of Illinois College of Medicine emergency medicine residency program. He received his medical degree from the Medical College of Wisconsin.

Raymond J. Sloan, MD,* has relocated to Platteville from the Marshfield Clinic-Lakeland Center. The family physician is a graduate of the Medical College of Wisconsin. Dr Sloan played an instrumental role in the construction of the Marshfield Clinic-Lakeland Center complex in 1991.

Alan D. Strobusch, MD,* a family physician and current president of the Wisconsin Academy of Family Physicians, has relocated to Waupaca where he has joined Waupaca Family Medicine Associates, SC. Prior to the move, Dr Strobusch practiced in New London for 9 years. Dr Strobusch is a 1980 graduate of the University of Wisconsin Medical School. He completed a residency at St Mary's Hospital Medical Center in Madison.

Clifford Tenner, MD, has joined the New Richmond Clinic. Dr Tenner will practice obstetrics along with family practice. He graduated from the University of Texas-San Antonio Medical School in 1989 and completed his residency at John Peter Smith Hospital in Fort Worth.

Jeanne M.K. Valicenti, MD,* a dermatologist, has joined the Sheboygan Clinic. Dr Valicenti received her medical degree at State University of New York at Stony Brook School of Medicine. She recently completed a residency at Rush-Presbyterian-St Luke's Medical Center in Chicago.[150th]

Physician-Citizen of the Year nomination letter

Two years ago, the SMS opened to the public the nomination process for its Physician-Citizen of the Year award. The result was an overwhelming outpouring of admiration and affection for Wisconsin's physicians. As a service to the members of the SMS, the *WMJ* will begin sharing some of these nominating letters with its readers.

The letters, the first of which appears below, will be reprinted edited only for length and the removal of personal names. The letters reprinted are not necessarily the nominations of the winning physicians.

For over 36 years, Dr – has been the doctor, counsellor and friend of the people in our community. First as a doctor of osteopathy and health inspector, then as an MD on the hospital staff.

Dr – has been known to sit up all night with a patient who suffered a heart attack. On another occasion, he promised a bikini bathing suit to a patient who promised to lose weight that was interfering with her health, and did. In our case, he made house calls after his long and busy day at his office, when my mother was no longer able to come to the office. Once, when the river was up and water was all around our house, Dr – walked on cement foundation blocks to come in our house to take care of my mother. He is on call day and night and can always be reached in an emergency. Most of his patients have been with him since he began his practice, and now their children are his patients.

Our community is healthier and happier because of the caring of Dr – who deserves to win the Physician-Citizen of the Year award.[150th]

Questions?
Call the
State Medical Society
of Wisconsin
1-800-362-9080.

CESF donors

The persons and organizations named below made contributions to the Charitable, Educational and Scientific Foundation from June 1 through Aug 31, 1992.

Beaumont 500 Club
In recognition of those individuals, county medical societies and auxiliaries who contribute their support to this Fort Crawford Medical Museum:
Waukesha County Medical Society Auxiliary

150th Anniversary Contributions
Loren E. Hart, MD
Stephen D. Hathway, MD
Dr and Mrs Richard Ulmer
Warren H. Williamson, MD

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.[150th]

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Donn D. Fuhrmann, MD
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Continued on next page

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In Memoriam

In loving memory of those individuals who will grace our paths forever:
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Walter P. Blount, MD
William T. Brodhead, MD
Anthony T. Buscaglia, MD
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Richard W. Zuehl, MD[150th]

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The cover letter must also designate one author as correspondent and provide a complete address and telephone number. All coauthors should have contributed to the study and manuscript preparation. They should be thoroughly familiar with the substance of the final manuscript and be able to defend its conclusions.

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All manuscripts will be edited by the *Journal* staff for clarity, organization, grammar, spelling, and punctuation, and in accordance with AMA style (AMA *Manual of Style*, 8th ed, and AMA *Manual for Authors and Editors*). Suggestions for titles are welcome, but are subject to the constraints of clarity, space, grammar and style.

The corresponding author will be asked to review a galley proof prior to publication to verify statements of fact. Galley proofs are for correcting errors; revisions should be made before submission, but must be made prior to final acceptance of the paper. The authors are responsible for all statements made in their work, including any changes made by the editors and authorized by the corresponding author.

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- Submit papers to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701; Ph: 608-257-6781 or 1-800-362-9080; FAX: 608-283-5401.
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- Typed manuscripts must be submitted in triplicate (one original, two photocopies). Type on one side only of standard-sized white bond paper, using 1-inch margins. Double-space throughout.
- Organization for scientific papers:

Abstracts–150 words or less, stating the problem considered, methods, results and conclusions. Cite no references.

Methods–Describe the selection of observational or experimental subjects, including controls. Identify the methods, procedures and equipment well enough to allow replication.

Results–Provide results in the test, tables or illustrations. If tables or illustrations are used, emphasize or summarize only the most important observations in the text.

Discussion–Discuss the conclusions that follow from the results, as well as their limitations and relations to other studies. Show how the conclusions relate to the purpose of the study. Recommendations, when appropriate, may be included.

References–Limit to 20. Authors are responsible for the accuracy and completeness of references. References must follow AMA style and abbreviations of journal names must follow those in *Index Medicus*. Consult the *Wisconsin Medical Journal* for examples of proper form.

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- Provide each author's full name and highest academic degree in the byline. If an author holds two doctoral degrees (eg, MD and PhD, or MD and DDS), either or both may be used, according to the author's preference. Honorary American designations (eg FACP or FACS) are omitted. If the author holds a doctorate, master's and bachelor's degrees are omitted. Courtesy titles (eg, Mr, Mrs, Ms) are omitted from bylines and text.

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Chippewa Falls, Wisconsin. Emergency department opportunity available at client hospital in Chippewa Falls. Annual ED volume of 9,000 in this 149-bed hospital. Progressive facility with well equipped ED. Excellent nursing support and a wide variety of medical specialty backup. The selected candidate will have the option of assuming the director position or contracting as a staff physician in this ED. Requirements include BC in emergency medicine or a primary care specialty, ACLS and ATLS. Annual fees in six figures and reimbursement of Wisconsin Comp Fund. Director also offered a full benefit package, administrative stipend, and participation in retirement plan after 12 months of service. Chippewa Falls is located 20 minutes north of Eau Claire and one hour east of the Twin Cities. Several lakes and ski areas are close by. Contact Mallarry Dierkes, Spectrum Emergency Care, P.O. Box 419052, St. Louis, MO 63141; 1-800-325-3982, ext. 1029. 9-10/92

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Family practice. Fifth BC/BE physician needed to join stable, progressive group practice. Beautiful northwestern Wisconsin location near Twin Cities with outstanding medical community, hospital, schools and nearby university. Many lakes offer year-round recreation. Competitive compensation package. Send CV or contact Cindy Wendel, Family Health Associates, 2449 County Trunk I, Chippewa Falls, WI 54729, (715) 723-9138. 8-9/92

Family physician/North Central Wisconsin. Excellent opportunity to join four board certified family physicians. Highly competitive salary and fringe benefit package. Modern recently expanded hospital offers full range of medical specialists including fulltime emergency room coverage. Office fully equipped with lab, x-ray, ECG, minor surgery and flexible sigmoidoscopy. Area is surrounded by lakes and woods providing hunting, fishing, skiing and other year around recreational activities. Send CV to: Brian D. Smith, MS, 212 Sturgeon Eddy Road, Wausau, WI 54401. 8-9/92

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Physicians Exchange

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The Appleton Family Practice Residency Program is looking for a residency-trained, board-certified family physician for the position of Program Director. The program is affiliated with the University of Wisconsin-Madison. Located in the Fox River Valley, one of Wisconsin's fastest-growing areas, the program enjoys strong support from the medical and business communities. The Program Director will be responsible for supervising all administrative, clinical, and education activities of the residency. Current faculty include four full-time family physicians, two with fellowship training and one with CAQ in geriatrics, one full-time clinical psychologist, one full-time health educator, and one part-time nurse practitioner. The 18-resident program is based at two excellent community hospitals, and operates an independent Family Health Center in downtown Appleton. Faculty are involved in teaching in an evolving innovative curriculum, patient care, administration, and research. Obstetrics is optional; skills in obstetric teaching a plus. Candidates should have experience or strong interests in innovative leadership of a creative and caring community of health care professionals. Strong interpersonal and organizational skills are required. Academic level at the Assistant or Associate level, depending on qualifications. Respond with letter of interest and CV to Robert E. Garrett, MD, MS, Acting Program Director, Appleton Family Practice Residency Program, 229 South Morrison Street, Appleton, WI 54911-5760. Tel: 414-832-2789. The University of Wisconsin is an Equal Opportunity Employer. 9/92

Family practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr. Paul Hayes' office (906) 563-9255 or Dr. William Gladstone's home (906) 563-8743. Anderson Memorial Hospital, Main Street, Norway, Michigan 49870, (906) 563-9243. 8-9/92

Wisconsin. Family practitioner needed by a growing practice of a four physician group in a friendly rural community in northeast Wisconsin near Green Bay. This is an excellent opportunity to join an established organization. Highly competitive salary with benefits. Please contact: Artwich Clinic, Oconto Falls, WI 54154. p7-12/92

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9-11/92

Family practice - Internal medicine to join seven BC family practice physicians and one BC general surgeon in beautiful northern Wisconsin. Clinic facility is attached to hospital and new nursing home. Resort area. If your family life and life style are important to you, this is the opportunity. Contact Stephen Carlson, MD, or Jeanne Chamberlain, Adm, Northwest Medical Center, 707 Ash Street, Spooner, WI 54801; ph 715-635-2151. 7-12/92

Madison, Wisconsin. Positions available: family practice and locum tenens in family practice (full time). Excellent salary, benefits, lifestyle. Contact Professional Staff Coordinator, Group Health Cooperative, 1 South Park St, Madison WI 53715; ph 608-251-4156. GHC is an equal opportunity/affirmative action employer. 6-7/92;tfn/92

Pathologist. Locum tenens. Long term locums position available with an active hospital based group in southeastern Wisconsin. Please reply to Pathologists, PO Box 62, Elm Grove, WI 53122. 7-9/92

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RESIDENCY DIRECTOR

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Physicians Exchange

Continued

central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD, MBA, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 7-9/92

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Southeast Wisconsin. Well established, 39-physician multi-specialty group is seeking an energetic, motivated family physician. Unlimited potential. Full scope of family practice cases. No obstetrics. This progressive community offers exceptional recreational cultural and educational opportunities. Lake Michigan is at your doorstep. Position carries a competitive first-year guaranteed income and excellent benefit package. Contact Bob Suleski, 250 Regency Court, Waukesha, WI 53186; 1-800-338-7107. 7-9/92

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Staff psychiatrist. Medium-size smoke-free environment medical center offers primary and extended care to a large area of west central Wisconsin. Full range of psychiatric services include admissions (acute), geriatric, long-term care, out-patient, PTSD, and alcohol.

ASSISTANT PROFESSOR IN FAMILY MEDICINE

Eau Claire Family Practice Residency offers a faculty position for a residency-trained, board-certified Family Physician with practice experience to share teaching, administration and clinical practice in this University of Wisconsin 18-resident program. Eau Claire is located in the lake country of northwest Wisconsin 90 miles from Minneapolis-St. Paul. The program has special expertise in outpatient procedures, family systems, women's health care and international health and educational strengths in internal medicine, pediatrics and obstetrics. We invite you to join our family physicians, nurse practitioners, nutritionist and behavior science staff in providing solid residency education and quality patient care in Eau Claire as faculty of the University of Wisconsin Medical School Department of Family Medicine and Practice. For more information, send CV or contact Todd Swanson, MD, Program Director, Eau Claire Practice Residency Program, 807 S. Farwell, Eau Claire, WI 54701. Telephone (715) 839-5175; FAX (715) 839-4733. An Equal Opportunity/Affirmative Action Employer. 8-10/92

WE NEED FPs, INTERNISTS, PEDIATRICIANS

From large groups that provide unmatched quality of life to solo settings that offer tremendous income potential, career opportunities in Wisconsin are available for Family Practitioners, General Practitioners, Internists and Pediatricians:

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- Join 10-member FP group or affiliate with general surgeon. FPs or Internists can live in natural paradise, have academic affiliation and enjoy up to 9 weeks vacation. Modern 20,000 sq. ft. clinic available.
- FPs can earn $125K, have their practice managed by someone else and live on a lake. Obstetrics optional.
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- Internist can earn $150K in personal income and live 45 minutes from two metro areas. Work in new clinic on campus, and affiliate with modern, clean, 100-bed acute-care hospital.

Let all four of these positions pay for your disability, family health, life, and malpractice insurance, plus relocation and professional expenses. For more information from someone who has seen these communities and others throughout the Midwest, call or send your CV to Bill Cox at:

Harris Kovacs Alderman
5420 Southern Ave. West, Suite 407
Indianapolis, Indiana 46241
800/776-7901; FAX: 317/247-8533
9/92

Physicians Exchange

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Medical Meetings-Continuing Medical Education

September 19, 1992. The Milwaukee Academy of Medicine and the Continuing Medical Education Department of the Medical College of Wisconsin will present a symposium on domestic violence at the Pfister Hotel in Milwaukee, Wisconsin on Saturday, September 19, 1992. Topics covered will include recognition and assessment, community resources and legal issues relating to battered women. The keynote speaker will be Dr. Anne Flitcraft who has done pioneering research in the area of battered women. For information call Amy John, Executive Director of the Milwaukee Academy of Medicine, 414/257-8249.
g8-9/92

October 15-18, 1992: 44th Annual AAFP Scientific Assembly in San Diego. Info: AAFP, 8880 Ward Pkwy, Kansas City, MO 64114; ph 816-333-9700; 816-822-0580 (FAX). g3-9/92

October 23, 1992: *Lyme Borreliosis Symposium*, Minneapolis, Minnesota. This symposium is designed to update physicians and other health care professionals on the diagnosis and treatment of Lyme Disease. Sponsored by Abbott Northwestern Hospital, the Minnesota Institute of Public Health, and the Lyme Disease Coalition of Minnesota. For more information contact the CME Office at Abbott Northwestern Hospital at 612-863-5461.
8-9/92

November 8-12, 1992: Ninety-Sixth Annual Meeting of the American Academy of Ophthalmology at Dallas Center. Contact: The American Academy of Ophthalmology, Meetings Dept, PO Box 7424, San Francisco, CA 94120-7424; ph 415-561-8500. g3-9/92

AMA

December 6-9, 1992: Interim House of Delegates, Nashville.
June 13-17, 1993: Annual AMA House of Delegates, Chicago.
December 5-8, 1993: Interim House of Delegates, New Orleans.
June 12-16, 1994: Annual AMA House of Delegates, Chicago.
December 4-7, 1994: Interim House of Delegates, Honolulu.

Specialty societies meetings - 1992

Wisconsin Society of Otolaryngology, Oct 3, Heidel House, Green Lake

Wisconsin Chapter, American College of Emergency Physicians - Oct 29, Oshkosh

Wisconsin Dermatological Society Nov 14, Milwaukee

Wisconsin Chapter, American College of Surgeons, Nov 13-14, Midway Motor Lodge, Brookfield

State Medical Society of Wisconsin

Dates and locations of
ANNUAL MEETINGS
1993-1994

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1993 - April 15-17: La Crosse Convention Center, Radisson
1994 - April 14-16: Milwaukee

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

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Physicians Referral Network
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Palisades Pharmaceutical 551
Yocon ®
PBBS Equipment Corp 548
Peppino's Restaurant 546
Physicians Insurance Company of Wisconsin 526
Searle Company, G.D. ..... BC
Calan ® SR
SMS Services, Inc. 517
Northwestern National Life
SMS Services, Inc. 540
Trans Global 549
Wipfli Ullrich Bertelson CPAs 534
Wisconsin Research Network 531

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 55 cents per word, with a minimum charge of $25.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg*, copy for the August issue is due by July 1. Address communi-cations to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

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References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus.* New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol.* 1990;66:131-151. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol.* 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation.* 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology.* 1988;39:1025-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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Contents

October 1992 Vol. 91 No. 10

Opinions

569 *President's page*
Politics and war
by William J. Listwan, MD, West Bend
572 *EVP report: How I see it*
Keeping the lid on Pandora's box
by Thomas L. Adams, CAE, Madison

Scientific

577 A report of the SMS ad hoc Committee on Pain and Disability
by Charles A. Capasso, MD, chair
577 Management of neck pain
by Samuel Idarraga, MD, Marshfield
579 Musculoskeletal pain and work disability
by J. T. Harrington, MD, Madison
581 Occupational low back pain: prevention of chronic disability
by C. A. Capasso, MD, Neenah
583 Occupational soft tissue disorders of the hand and forearm
by Larry Livengood, MD, Appleton
585 Fibromuscular pain disorders in the injured worker: accurate examination is the key to diagnosis
by J. T. Harrington, MD, Madison

Socioeconomic

589 Assessment of disability status: the role of the physician
by Sridhar V. Vasudevan, MD, Milwaukee
591 Review process for reasonableness of fees and necessity of treatment disputes involving Worker's Compensation cases
by Cecilia Geis, SMS health policy analyst
595 Physicians and the Worker's Compensation System
by Sridhar V. Vasudevan, MD, Milwaukee
597 *Public health*
Breast cancer survival in Wisconsin
by Paula M. Lantz, PhD; Patrick L. Remington, MD; and Barthelemy Kuate Defo, PhD, Madison

Organizational

599 The Gundersen legacy
603 A glimpse into our past
by Richard D. Sautter, MD, medical editor
604 Physician briefs
606 County society news
607 Obituaries
610 AMA awards

Our cover: Adolf Gundersen, MD. See related story on p. 599. Photo courtesy of Gundersen Clinic.

Wisconsin Medical Journal

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Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's page

Politics and war

The soldier often regards the man of politics as unreliable, inconstant and greedy for the limelight. Bred on imperatives, the military temperament is astonished by the number of pretenses in which the statesman has to indulge. The terrible simplicities of war contrast strongly to the devious methods demanded by the art of government. The impassioned twists and turns, the dominant concern with the effects produced, the appearance of weighing others in terms not of their merit but their influence–all inevitable characteristics in the civilian whose authority rests upon the popular will--cannot but worry the professional soldier, habituated as he is to a life of hard duties, self-effacement, and respect for services rendered.

–Charles De Gaulle

William J. Listwan, MD

Charles De Gaulle's explanation of the professional soldier's view of politicians is a striking one. I think a comparison could be made between the soldier's and physician's view of politicians. This may explain some of the cynicism that our profession seems to have toward politics in general.

Physicians like to approach problems or issues "scientifically" and place things into "disease categories." We like to "stand up for our principles." Even though medicine is very much an art, we like to emphasize the scientific part of medicine which includes definition, organization and categorization of terms, diseases, and treatments. All of these are valuable attributes in the world of medicine, but a certain flexibility is needed in politics and things are not as easily categorized or measured. This makes it more difficult for us to become involved in the political process. Because we don't understand it and can't control it, physicians get frustrated and tend to withdraw. This is not a good time to withdraw. It is a good time to move forward and engage the political process more actively.

As the November election approaches, I find myself reflecting on the average physician's attitude toward politics and politicians. Recently, I heard a political scientist say that we can frequently learn a great deal about what a word means by analyzing its derivation or etymology. Many of you would agree with his analysis of the word "politics." He stated that the word "politics" is derived from the Greek word "poly" meaning many, and the English word "ticks" meaning blood sucking insects.

I have sometimes been referred to as a politician. The term was not being used in a complimentary way. Although I do not embrace the term politician, I will admit that I must have some political instincts or I would not be president of our State Medical Society.

Since I apparently am a politician, I have concluded that there must be a good side to being one. In my mind, being a politician does not mean abandoning principles. It means leading an organization or a group of people and moving them forward while trying to take into account their varying viewpoints and objectives. It means being able to prioritize your principles and goals in life while maintaining your personal integrity and working for the good of the organization. This approach allows you to compromise on those issues that are of less importance and to spend more time and energy on the issues that are more important.

Although some changes have occurred since I began practice 18 years ago, many physicians still have a disdain for the political process and try to avoid any involvement. I am convinced that physician involvement on a personal level in our political process is essential. Registering to vote, and actually voting, are relatively simple and very personal actions. Not even bothering to vote implies extreme cynicism and a significant rejection

Continued on next page

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of politics and of the political process. No other type of involvement could possibly erase the harm that is done by not voting.

I think that we, as individuals, must examine our consciences and make sure that we really make an effort to vote in every election. Our family members must also be encouraged to vote. From small things like a commitment to registration and voting, bigger and better things will happen.

On a local level, I see more involvement by physicians and county medical societies with their representatives in Madison. I think this dialogue is good, leads to mutual understanding, and from mutual understanding will come more cooperation. We all have to recognize that we need to talk to our representatives when we have good things to say as well as when we want something or have something critical to say to them. Making phone calls or writing letters only when we are angry or when we are asking for a favor isn't nearly as productive as regular contact.

I look forward with anticipation to the "mini-internships" that will take place in three Wisconsin counties this year. The involvement of these county medical societies and the type of contact with our legislators and business people that will occur through it will be very valuable. Bob Phillips and his committee are to be congratulated and offered our encouragement.

Political contributions and participation in the campaign process are signs of even a higher commitment on the part of physicians. When you find a candidate that you like, someone who understands your viewpoint, someone who frequently (not always) agrees with you, what better way to let them know this than to get behind them financially and emotionally. The emotional involvement may be as simple as a yard sign or bumper sticker. For those more adventuresome spirits, more personal and direct participation in a campaign can be an interesting and rewarding experience.

Several years ago, I became involved in the campaign of one of the candidates for Bill Proxmire's Senate seat. I was involved at the primary level and my candidate did lose in the primary election. Helping to organize a "Physicians Committee" to support my candidate's campaign, writing letters, soliciting contributions, and making lots of phone calls was tiring, frustrating, and not always easy to do. Nonetheless, I enjoyed the experience and, in the proper circumstance, would consider doing it again.

No, I am not a political junkie. I'm just someone who believes in the process and believes that physicians and their families must be involved in the process if we are to have any effect on it. I also believe that those that tune out and do not participate in the process have absolutely no right to complain.

I encourage all of you to make sure that you are registered to vote and to exercise your constitutional right to vote this November. As a second step, make sure you support and join WISPAC, the political action committee of your State Medical Society that is working for you in the political arena. Better yet, become personally more involved in the political process at any level you choose. You will find the experience rewarding, and you will have an effect.[150th]

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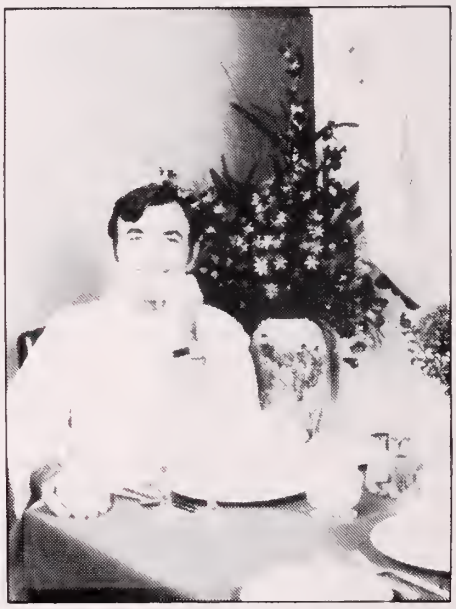

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EVP report: How I see it

Keeping the lid on Pandora's box

John Adams, one of our Founding Fathers and our second president, once quipped that "Practical politics consists of ignoring the facts," and I dare say he is as right today as he was 195 years ago. A number of Wisconsin politicians are now pushing for an alteration of our state constitution's uniformity clause, which mandates that all classes of property owners within a tax jurisdiction receive equal treatment. The justification offered is that property taxes on homeowners are too high, on businesses too low, that this arrangement is unfair, and that the uniformity clause prevents the Legislature from providing homeowners with tax relief. Free the Legislature from its constitutional constraints, the argument goes, and it will lower our taxes. That notion falls, I believe, in the category of ignoring the facts.

What I find disturbing is that anyone would accept the fantasy that *any* legislature would use such a new tax power to *lower* taxes. It is not the nature of the beast. There are too many powerful interest groups crying for more money for too many legitimate causes. The list of useful, important and politically–even morally–compelling programs that are chronically under-funded is long. True, the state government does not have the revenue to address all of our social ills, nor should it, but politicians are powerless to resist such demands of their own volition. Until the day politicians find the strength to say "no" to even their own causes, constitutional limits seem to be the only things that save us from being crushed by tax burdens.

As an aside, let me clarify that I am not pointing fingers at any one political party or any one branch of government. Both the Republicans and the Democrats, both the executive and the legislative branches, have constituencies they feel they must respond to with state dollars. The only difference lies in their priorities of who gets how much.

I am not unsympathetic to the complaints of homeowners, being one of them. The 144-year-old constitutional provision is not now the creature it once was. Five amendments to the uniformity clause and 80 exemptions from taxation have provided preferential relief for several classes of property tax payers, but homeowners have not been among them (except for the lottery tax credit, the amount of which continues to be a political football). Is that fair? Is that prudent? Probably not. Is giving politicians more

Continued on page 574

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Continued from page 572
power going to remedy these ailments? Certainly not.

The fact is, in 1911 Wisconsin's politicians enacted an income tax as a form of property tax relief, but the relief never came. The property tax was thought to be a "substitute" for an income tax, but when the income tax arrived the substitute did not leave. Both taxes became permanent fixtures because of the demands on politicians to spend more.

The fact is, in 1961 Wisconsin's politicians enacted a sales tax, again as a form of property tax relief, but-again-the relief never came. With more tax revenue coming in, the politicians found they could spend more and make more constituents happy.

Opponents of the proposed amendment predict that even if property taxes are lowered by this effort, spending will not. The bill for the politician's spending will simply be shifted to other forms of taxation, some of which could result in higher prices for consumers and fewer jobs for our labor force. As business men and women, physicians, clinic managers, and hospital administrators are rightfully concerned about the full, and as yet unexplored, implications of this amendment.

The opponents of the amendment are probably correct, but I cannot agree that all tax shifting is harmful or inappropriate. When the burden becomes too heavy for one class of taxpayers, we are right to shift some of that burden (if we cannot eliminate it).

Providing for the education of our children and the future of our communities, our state, and our nation is one of those costs only the irresponsible would decline to pay. Those costs, as currently paid, are directly related to our property taxes, so eliminating this burden is not an option. In fact, we as a people are demanding ever more from our schools, and it would be unrealistic to demand that they accomplish more with fewer resources. So, this burden is one that must be shifted; we must find another way to pay for our schools.

This should be the focus of the debate, and, indeed, many of the citizens who attend hearings on this amendment arrive with the idea that finding an alternative way to fund education is the point. Let's hope the confusion is cleared up before we cast our votes on this referendum in November's general election. Let's hope we don't ignore the facts.[15th]

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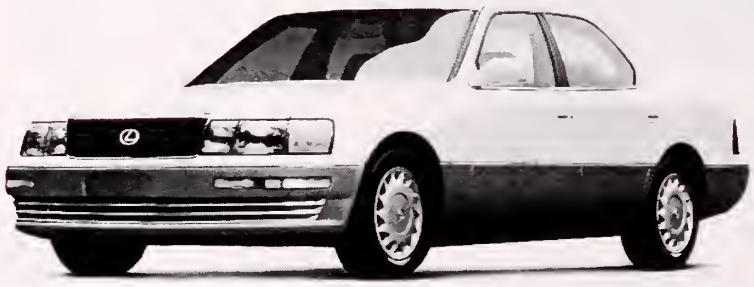

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A report of the SMS ad hoc Committee on Pain and Disability

Charles A. Capasso, MD, chair

THIS ISSUE of the *Wisconsin Medical Journal* contains a wealth of information on issues of pain and disability, all of which are products of the SMS ad hoc Committee on Pain and Disability. I have had the privilege of serving on, and chairing, this committee for several years, and am impressed that the committee members took on and brought to fruition a project of this magnitude. Throughout the history of mankind, committees have been known as unproductive entities, and I do not think it hyperbole to say that I am proud of this committee's accomplishments.

The committee's first goal is to emphasize the physician's role in prevention of disability in Worker's Compensation cases through: 1) early intervention and aggressive "good medicine"; 2) an understanding of Worker's Compensation definitions and reporting system; and 3) prompt and clear dissemination of information.

Our second goal is to provide updated medical information on the common soft tissue disorders so often associated with serious disability in Worker's Compensation cases.

Of course, our broader goal is to promote a better practice of medicine in Wisconsin. The quality of medicine in Wisconsin already ranks highly among the states, but the endeavor to provide ever greater care has been, and continues to be, the hallmark of the American medical profession. The pursuit of this goal is certainly a trait that characterizes Wisconsin physicians, their State Medical Society, and the *Wisconsin Medical Journal.* The SMS ad hoc Committee on Pain and Disability is proud to be part of this effort and this tradition.

Management of neck pain

Samuel Idarraga, MD, Marshfield

NECK PAIN MAY BE DUE to a wide variety of causes and, like lower back pain, the definite cause is not always clear. Neck pain may be associated with muscle tension and postural problems. Many pain syndromes outside the neck have their origin in the neck, including headaches, chest pain simulating angina pectoris, scapular and costal pain, and upper extremity pain. In young adults, the most common cause of pain is some kind of strain and tension, while in the older adults, osteoarthritis shows as a cause of neck problems and results in limitation of motion and pain when the limited motion is exceeded.[1]

Knowledge of the basic functional anatomy of the neck is essential for understanding the mechanisms of pain production and dysfunction of the neck. A good reference may be found in *Neck and Arm Pain* by R. Calliet.

Successful management of neck pain depends on a thorough medical history including psychosocial, environmental, and emotional factors; a complete physi-

Dr Idarraga is a member of the SMS ad hoc Committee on Pain and Disability. Reprint requests to: Samuel Idarraga, 1000 N Oak Ave, Marshfield, WI 54449-5777. Copyright 1992 by the State Medical Society of Wisconsin.

cal examination; and the best available tests. The goals of treatment should be early resolution of acute pain, identification of high risk for chronicity, prevention of its development, prevention of recurrence and proper treatment of the anxiety resulting in reaction to the pain. Physicians should avoid prescribing prolonged rest as it can rapidly result in functional and psychological debility.[2]

Some of the most common neck pain conditions are summarized below.

Degenerative arthritis

Degenerative changes in the tissues of the vertebral column occur to some extent in all individuals after early adult life. These changes are part of the aging process and, as a result, radiographic changes in the cervical spine are common. Well-advanced radiographic degenerative changes, however, may be asymptomatic, and in many patients with degenerative arthritis the pain can be due to other causes. Sclerosis, osteophytosis and disk space narrowing are radiographic changes of disk degeneration. In the early stages, pain seems to be of mechanical origin. Cervical osteophytes develop by ossification of the periosteum, which has been displaced from the edge of the vertebra by a bulging annulus or by traction due to abnormal intervertebral mobility. A pair of spurs is typically found due to the adjacent stimulative traction on the periosteum (hard disk). Vertebral Artery Syndrome may result from encroachment of the vertebral artery foramen.[4] Symptoms of this syndrome are dizziness, tinnitus, and intermittent blurring of vision.

Tests: In the majority of cases, there is no need for more than standard roentgenogram of the cervical spine.

Treatment options: First, provide a clear explanation of the nature of the problem and then use nonsteroidal, anti-inflammatory medications in short duration and mild analgesics. Physical therapy modalities are useful and can be prescribed for a short time, for example, three times per week for 2 to 3 weeks. The patient should be instructed in home therapy modalities such as intermittent cervical traction, moist heat, simple exercises, body mechanics, good posture, and avoidance of certain heavy or strenuous activities.

Cervical disk disease

Pain originating in the neck, but felt in the shoulder, arm, hand, or neck itself most frequently results from irritation of nerve roots in the region of the intervertebral foramina.[4]

Radicular pain varies from a deep, aching pain to a sharp pain superimposed on a dull, aching background. It is common for radicular pain to be felt proximally and paresthesia or a sensation of numbness to be felt distally.[4]

The most commonly affected nerve root is C7, which manifests by pain in the posterior part of the arm and dorsum of the forearm, weakness of the elbow extensors and wrist extensors, pronator teres, extensor pollicis longus, reduced triceps reflex, and numbness of the index and middle fingers. The C6 nerve root is next in frequency of compromise and may cause pain in the arm, sometimes also in the forearm, numbness or paresthesia of the thumb, decreased or absent biceps reflex, and weakness of elbow flexors and forearm supinators. The C5 nerve root causes pain in the shoulder region, including the supraspinatus and infraspinatus regions, weakness of the arm abductors and external rotators and some reduction of the biceps reflex. The C8 nerve root is rarely involved, but can cause weakness of intrinsic muscles of the hands, the extensor carpi ulnaris and paresthesia of the fifth digit. Most muscles, most reflexes and sensory dermatomal patterns have multiple nerve root innervation.[4]

Tests: Most cases must be evaluated through electrodiagnostic studies, standard roentgenogram of the spine and MRI.

Treatment options: Rest at home for a few days, a short course of oral steroids or an epidural steroid injection, analgesics, nonsteroidal anti-inflammatory medication, gentle intermittent cervical traction, moist heat application, soft collar, a sling to decrease traction of the upper extremity on the tissues affected, and, finally, surgery if conservative measures fail.

Whiplash syndrome

Sudden extension of the neck may occur following a rear-end automobile collision.[3] Sudden flexion of the neck may occur with front collisions. Cervical whiplash is an injury of the soft tissues above the cervical spine, but the term is most accurately defined as a musculoligamentous sprain or strain of the neck. The diagnosis is determined by the history provided, the mechanism of injury, the symptoms and the physical findings on examination. The diagnosis excludes fractures and disk herniation.[3]

Ninety-five to 98% of neck injuries are mild.[5] A mild degree of hyperextension may be overshadowed initially by the emotional reaction. Discomfort, stiffness or pain may not be evident until minutes or hours later, but all of those conditions are usually fully pronounced the day after the accident.

Adjunctive studies: Full radiographic evaluation should be used to rule out fractures. When feasible, flexion-extension views can be used to assess instability. If there are symptoms of nerve root irritation, electrodiagnostic studies at the right time are of value, a CT scan or MRI may be necessary and, in certain cases, myelography of the cervical spine may also be necessary.

Treatment: Initial treatment includes protection and immobilization; wearing a soft collar for a few days may help. Milder cases may require rest and restriction of activities for a few days, mild analgesics, and reassurance. More severe cases may require bed rest. The use of analgesics, muscle relaxers, and anti-inflammatory medication is appropriate in short duration, with physical therapy measures to relieve pain and spasm, and to improve mobility. A physical therapy program should have specific goals and should be discontinued when there has been sufficient improvement to allow a home program or when lack of improvement indicates ineffectiveness.[3]

Myofascial pain

(Editor's note: Although myofascial pain and fibromyalgia will be the subject of another article in this series, it is mentioned briefly here as another common source of neck pain.)

Myofascial pain is a sensation of pain referred from a trigger point. A trigger point is a small, hyperirritable focus within the skeletal muscle or its fascia which produces pain in a wide region around itself when stimulated.

Tests: There is no laboratory test or radiographic study that will identify this condition. The diagnosis is based on medical history, exclusion of other problems and identification of trigger points.

Treatment: The key to treatment of acute myofascial pain syndrome is identifying the specific muscles harboring trigger points. Lasting success in treatment depends on education of the patient, inactivation of the responsible trigger points through spray, and stretching techniques of the involved muscles or injection of the trigger points. It is critically important to teach the patient a home self-stretch program, as well as muscle relaxation procedures. The patient must learn how to use, not abuse, the involved muscles. Psychosocial issues are often of critical importance in myofascial pain.

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Musculoskeletal pain and work disability

J. T. Harrington, MD, Madison

Musculo-skeletal pain caused by neck and back injury, cumulative trauma to the upper extremities, fibromyalgia, and reflex dystrophy is an important cause of worker disability. Physicians are involved not only in the care of injured workers, but in providing independent medical opinions regarding such injuries. Advances in medical knowledge permit better understanding and management of these injuries, and it is the responsibility of all physicians to provide accurate diagnosis, treatment, and information to patients, employers, insurers, and the workers compensation system. *Wis Med J.1992;91(10)579-580.*

In 1986, the State Medical Society of Wisconsin became aware of increasing concerns among members regarding disagreements on terminology and reimbursement vis-a-vis the issue of chronic back and neck pain in the worker compensation and disability field. In 1987, an ad hoc Committee on Pain Evaluation and Disability was formed to consider these concerns. This committee has been active during the last several years, has collected information from many sources, and has interviewed representatives of industry, the legal profession, and the workers compensation system. In particular, a close cooperation has developed with the Wisconsin Workers Compensation Division.

The committee has become aware of numerous problems that exist in the diagnosis and management of injured workers, and in the administration of disability claims for injuries. While these problems may be due in part to competing interests inherent in the system, the committee is more concerned with controversies resulting from conflicting medical expert opinion and failure to apply current information to the diagnosis and timely management of those musculo-skeletal conditions that may produce chronic pain and disability.

The purpose of this Committee on Pain and Disability report is to improve the information available to physicians and others involved in work-related injuries. The committee members hope this will result in improved medical care for the injured worker; more timely and appropriate decisions regarding such injuries; and more cost-effective administration of such injuries under workers compensation.

The initial report consists of two parts: this overview and a series of articles on specific musculo-skeletal problems seen as frequent causes of disability in the work place.

Musculoskeletal pain

Musculoskeletal pain is a symptom associated with increasingly frequent work disability in Wisconsin. No group of injuries cause greater problems in diagnosis; questions as to appropriate management; and disagreements as to the degree of temporary and permanent disability. These

Dr Harrington is a member of the SMS ad hoc Committee on Pain and Disability. Reprint requests to: J. Timothy Harrington, Jr, MD, 20 S Park St, Suite 301, Madison, WI 53715.

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controversies translate into less than optimal treatment for the injured worker; prolonged and expensive fact finding and litigation; and increased disability costs.

Pain is difficult to measure as it varies in degree from one to another individual with similar injury, and evokes differing emotional responses and adaptations in injured individuals. Differing perspectives, priorities, and biases appear to affect the opinions and behaviors those involved: the injured worker and family, the employer, fellow workers, insurance carriers, administrative law judges, attorneys, physicians, other health care providers, and rehabilitation counselors. These influence decision-making and may actually interfere with medical treatment.

Yet the common goals of all involved should be to accurately evaluate and diagnose the causes of the worker's pain and disability, to promote a timely relief of symptoms and resumption of optimal function, to minimize the emotional impact on the injured worker, and to control the costs of the injury, its treatment and its administration.

Medical knowledge of pain

Medical knowledge about chronic musculoskeletal pain is improving, but the treatment of pain-producing injuries is not keeping pace. For example, the evaluation of neck and back pain continues to focus on intervertebral disc herniation and bony pathology–no disc, no fracture, no disability–and no basis for chronic pain.

In contrast, it is commonly believed that neck and back sprains always heal in a few weeks, and, therefore, a rapid return to work should be possible. When the worker continues to report pain and cannot return to work, his or her motives and emotional stability rapidly become the central issue, and the worker predictably begins to demonstrate such behaviors. Optimal treatment strategies are too infrequently applied during the initial weeks of disability when they can be most effective, and injured workers are seldom given the option of returning to modified work.

A better understanding, however, is developing of other pain-producing conditions that may delay expected healing, slow return to work, and subject the worker to risk of re-injury. Recognition of the interplay of pain, disability, and emotional factors is altering the way informed physicians approach injury management. Comprehensive approaches to treatment and rehabilitation are being developed, and physician experts now exist in this challenging area of medicine. Other health care professionals have also evolved expertise in this field, and a multidisciplinary approach to injury and pain management is now recognized in the scientific literature as essential to favorable outcome.

Important medical developments are accounting for these advances. One is clinical research interest that is better defining important pain disorders and their treatment. Another is the development of new technologies–CT scanning, magnetic resonance imaging, tomographic isotope bone scanning that better identify the anatomy of injuries and the sources of pain in the spine that can not be seen on conventional roentgenogram until years later when degeneration becomes evident.

Unfortunately, this information has not yet influenced the way in which many work-related injuries are managed. The residency and post-graduate training of many physicians and chiropractors involved in injury diagnosis and management does not include these concepts. The same can be said of those physicians who commonly provide independent evaluations for Worker's Compensation insurers. Because of this, injury management and the medical information provided by physicians is suboptimal and often contradictory.

Work-related injuries

Disorders that produce chronic pain and disability include the following:

- neck injury;
- low back injury;
- upper extremity pain disorders (cumu lative trauma disorder);
- myofascial pain and fibromyalgia;
- reflex sympathetic dystrophy; and
- chronic pain disorder.

Each of these disorders is complex. More than one may contribute to pain and disability in a single individual, and the reasons individual patients develop such complications of injury are as yet incompletely understood.

In particular, chronic pain syndrome (CPS) is being diagnosed with increasing frequency in work injuries, and symptomatic management of pain, its emotional aspects, and medication abuse are being emphasized. As defined by the Congressional Committee on Pain Evaluation in 1986, CPS has six features. These include intractable pain for more than 6 months; behavior alteration with depression or anxiety; marked restriction of daily activities; excessive use of medications and medical services; history of multiple nonproductive tests, treatments, and surgeries; and no clear relationship to organic disorder. Many patients show some of these behaviors, and this diagnosis should only be applied after expert evaluation excludes other mechanisms of chronic pain. This will restrict the potential overuse of emotional disorder to explain chronic pain associated disability.

Conclusion

Conditions that produce chronic musculoskeletal pain and disability in injured workers are often complex, but advances in medicine provide an opportunity for improved diagnosis and management of these disorders. It is critical that these advances be understood and applied in a timely fashion by those physicians and chiropractors who provide early management. In addition, employers, insurers, and physicians providing independent medical evaluations, attorneys, and administrative law judges must understand this information if the Worker's Compensation system is to reach accurate decisions on disability and facilitate an optimal outcome for both the injured worker and other involved interests.[150th]

Occupational low back pain: prevention of chronic disability

C. A. Capasso, MD, Neenah

Work-related low back pain is a major problem for both patients and employers. Although the cause of the pain is often unclear, patients failing to return to work within 3 to 6 months have a poor medical and economic prognoses. This article reviews issues relevant to the need for aggressive management of acute, work-related LBP cases. *Wis Med J.1992;91(10):581-582.*

THE FATHER OF OCCUPATIONAL MEDICINE, Bernadino Ramazzini, discussed lumbago among workers in 1690.[1] Our current understanding of low back pain (LBP) remains incomplete due to problems of definition, classification, diagnosis, and qualifications of physical exposures of etiological importance. The prevalence and economic cost of LBP are profound. Snook estimated the total compensable cost for LBP in 1980 and 1986 to be $4.6 billion and $11.1 billion, respectively. Current estimates exceed $20 billion annually. Most importantly, the cost accelerates as the duration of disability from LBP increases. Snook's 1986 data found 25% of LBP cases responsible for 95% of all the costs incurred from LBP.[2]

Physicians who attend to acute, work-related LBP patients, play a significant role in the prevention of chronic disability cases. A knowledge of the natural history of LBP, together with an awareness of factors which may facilitate or inhibit early and safe return to work, is crucial to effective management and prevention of occupation LBP. This article will review LBP issues relevant to effective prevention and management of acute, work-related LBP cases.

Dr Capasso is chair of the SMS ad hoc Committee on Pain and Disability. Reprint requests to: Charles A. Capasso, MD, 411 Lincoln St, Neenah, WI 54956. Copyright 1992 by the State Medical Society of Wisconsin.

Clinical features

Problems with standardized and validated terminology for LBP has led to a spectrum of heterogeneous findings in the literature and in practice regarding diagnosis, treatment and rehabilitation, as well as in the criteria for evaluating therapeutic efficacy. Never the less, there is general agreement on the following.

In general, LBP is a nonspecific, self-limiting disorder, which usually remits within 4 to 6 weeks, independent of the mode of treatment. Approximately 10% of cases go beyond 6 weeks, with 5% lasting more than 3 months. It is this 5% that can account, however, for up to 85% of direct and indirect costs associated with LBP.[3]

Many workers afflicted with LBP do not seek formal treatment. Those who do generally respond favorably to a short-term regimen of 1 to 2 days of bed rest, oral analgesics, exercises, and education, and are back to work in less than 1 month.[3,4]

A good history and physical examination alone, are usually sufficient to identify the majority of patients in need of specific therapeutic intervention. Diagnostic radiology is of limited value in the initial evaluation of LBP. In most cases, surgical intervention for LBP is indicated only after conservative treatment has failed.[3,5]

Quebec guidelines

The Quebec Task Force on Spinal Disorders, has proposed guidelines for management of acute, work-related LBP cases. In summary, time should be devoted at the initial visit to a more complete history and physical examination. Approximately 1% of patients will be younger than 20 or older than 50, with signs or symptoms of trauma, neoplasm, fever, neurologic deficit, or with history of recurrent LBP. Appropriate medical work-up and prompt referral to specialty care are usually required.

Restricted activity coupled with analgesic or nonsteroidal anti-inflammatory agents are initiated for the remaining cases, with 2 days of bed rest for more intense pain and spasm. Additional therapeutic modalities and education, possibly with a second short course of bed rest, would be used if pain persists.

If the patient has not resumed work after 4 weeks, a complete re-evaluation is performed, including roentgenogram and a sedimentation rate. Occupational therapy-work hardening is added to the treatment regimen. A specialist is consulted at the sixth week if the patient remains at home. Approximately 2% to 3% of LBP patients fail to return to work at 3 months, and require a multi-disciplinary team of specialists for the spine, psyche, and functional-occupational rehabilitation.[5]

Management and prevention

There is general agreement that reassurance of the favorable prognosis of LBP when such is the case, coupled with prompt return to work, makes sense medically and economically for both patient and employer.[3] It is important for the clinician to look for potential risk factors for LBP, both at the job site and with the patient, before attempting to expedite an early and safe return to work.

The influence of psycho-social factors on the continuation of pain toward a chronic phase is increasingly recognized.[6] Adverse employee relations, absent or ineffective work policies for injured

workers, and frequent litigation increases the risk of costly disability cases.[7] It is important for clinicians to provide clear and timely communication regarding the patients' fitness for duty when such issues are present, and to use employee assistance programs and other mental health resources when indicated. It is extremely important for clinicians not to allow themselves to be manipulated by either the patients or the employers into a position which could jeopardize an early and safe return to work.

Properly designed work hardening occupational therapy programs may be useful when work place modified duty programs are absent or limited. Improved patient body mechanics and cardiovascular fitness appear to have additional benefits as well. While an improved level of cardiovascular fitness may or may not affect the risk of acquiring LBP, it may favorably affect how a patient responds to an acute episode of LBP.[8] Persons who are at a high fitness level may have less costly claims and fewer recurrences than those who are less fit.[9] Successful outcomes from instruction on proper body mechanics at the work place, however, and musculoskeletal and cardiovascular fitness, appear to hinge on early intervention prior to or during the acute LBP phase.[4]

Ergonomic deficiencies at the work place often correlate highly with the reports of pain and injury.[1] They can be corrected through administrative or engineering controls, such as rotation of workers and utilization of mechanical lifting devices respectively. Employer investment in engineering controls need not be cost prohibitive. Snook estimated that if a proposed $6,000 control measure can prevent one compensable LBP case, it will be paid for in 1 year.[2] Proper job design can significantly reduce direct and indirect costs of LBP by reducing risk for its recurrence, by allowing the worker to stay on the job longer, and by permitting the worker to return to the job sooner.[11]

Static and dynamic strength testing, particularly when tailored to specific job requirements, may facilitate safe return of a LBP patient to his or her regular job.[12] Although manufacturers of such equipment may allude to the contrary, use of static and dynamic strength testing equipment as a general screening tool in the occupational setting presently backs demonstrable predictive value for future LBP.

In the absence of strength testing data, and where work place modified duty programs are less sophisticated, early and safe return to work can be facilitated when the following job factors are limited or avoided: 1) heavier, awkward lifting tasks; 2) repetitive bending and twisting at the waist; 3) prolonged standing or sitting in one position; and 4) prolonged exposure to vehicular vibration.[3,13,14] Again, it is important that the clinician communicate this information in a clear and timely fashion to all concerned parties.

Conclusion

Physicians who see acute, work-related LBP patients play a critical role in the prevention of expensive, disabling, chronic LBP cases. There are risk factors for LBP unique to the work place and the individual patient, respectively. These factors need to be identified and addressed appropriately to expedite an early and safe return to work following an episode of acute LBP. It is important that prompt, safe return to work be the common goal of all parties involved in the management of acute, work-related LBP cases.

The clinician must avoid inappropriate and ineffective treatment that may actually foster disability. A program of short-term bed rest, exercise, and education, with appropriately timed surgery, remains at the foundation of sound clinical management. Important factors in predicting disability relate less to physical findings and more to factors including duration of disability, history of previous disabling LBP, psycho-social factors, and adverse occupational exposures to the spine. More aggressive measures of intervention should be considered when patients fail to return to work in 1 month. Such measures include: timely referral to employee assistance programs and other mental health resources; use of properly designed occupational work hardening programs when flexibility for modified work place duty is absent; and prompt specialty consultation when pain persists.

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Occupational soft tissue disorders of the hand and forearm

Larry Livengood, MD, Appleton

Upper extremity work-related diagnoses are becoming more frequent as a source of chronic pain and lost work time for the injured worker. Early directed care toward diagnosis, treatment, and rehabilitation is needed to prevent a protracted course. A review of common regional problems of the upper extremity is presented. *Wis Med J.1992;91(10):583-584.*

Hand and forearm soft-tissue disorders constitute a significant portion of occupational-related injuries. It is the role of the physician to recognize the pathological condition, determine its work-relatedness, and institute appropriate treatment. Early recognition and directed aggressive care is necessary to avoid a chronic state where the patient continues to have active symptoms and remains absent from work.

Cumulative trauma is often a cause with these disorders. Ergonomic studies have shown that repetition, force, vibration, mechanical stresses, extreme postures, and cold temperatures are important factors associated with these conditions.[1]

It is beyond the scope of this paper to cover all occupational soft tissue disorders of the hand and forearm. The most common compression neuropathy, carpal tunnel syndrome, will not be presented; a regional approach will be taken to the discussion of: 1) lateral elbow pain; 2) radial wrist pain, and 3) ulnar wrist pain.

Lateral elbow pain

Lateral epicondylitis. Lateral epicondylitis, or "tennis elbow," is a painful condition that presents with acute tenderness directly over the lateral epicondyle, where the common extensor tendons originate.[2] These patients have accentuated pain on resisted wrist extension.

Passive wrist flexion may be aggravating and patients may have weakened grips. There is a lack of tenderness near the radial head where the posterior interosseous nerve penetrates under the leading edge of the supinator muscle.

Treatment is directed at decreasing aggravating activities and employing conservative measures such as physical therapy, nonsteroidal anti-inflammatory medications, occasional steroid injections into the proximal extensor tendon, wrist splints, and elbow bands to re-direct the forces on the common extensor. Surgery is only indicated in 5% to 10% of refractory cases. Early recognition and aggressive treatment can usually avoid the chronic longstanding problem and the need for surgery.

Radial tunnel syndrome. Radial tunnel syndrome is a much less common problem than lateral epicondylitis. It involves an entrapment of a branch of the radial nerve (the posterior interosseous nerve) usually at the proximal edge of the supinator muscle near the radial head.[3,4] A hallmark of this condition is pain and tenderness directly over the posterior interosseous nerve which is roughly 3 cm below the elbow joint through the mobile wad of the brachioradialis, extensor carpi radialis longus, and extensor carpi radialis brevis. Symptoms can be aggravated with resisted supination. There is less tenderness over the lateral epicondylar region and resisted wrist extension does not cause the pain typical of lateral epicondylitis. There is usually a decrease in grip strength and pain appears to migrate distally across the extensor surface of the forearm. EMG and nerve conduction velocity tests may be helpful in the differential diagnosis.

Treatment is directed at recognition and avoidance of the irritating activity. If no improvement is noted with conservative care, surgical decompression may be required.

Radial wrist pain

Stenosing tenosynovitis at the radial styloid "de Quervain's Disease." This condition is a localized stenosing tenosynovitis of the abductor pollicis longus and extensor pollicis brevis as they pass through the first extensor osteoligamentous compartment.[2] The patient complains of pain over the radial styloid. Occasionally, there is swelling and radiating pain into the forearm and thumb.

The Finkelstein's test, in which the thumb is clenched in the palm and the wrist ulnarly deviated, causes an exacerbation of the pain. Localizing tenderness is found over the first extensor compartment. Pain is increased with thumb movement but one must differentiate pain from that at the base of the first metacarpal. A roentgenogram is appropriate to rule out first carpometacarpal joint osteoarthritis and the snuff box pain associated with an occult scaphoid fracture.

Treatment involves recognition of irritating activities and their elimination. Immobilization of the wrist and thumb, anti-inflammatory medication, and steroid injections usually offer improvement. Lastly, should the patient's symptoms not improve, surgical decompression is warranted.

Flexor carpi radialis tendinitis. This is a common but overlooked cause of radial

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wrist pain. The patient has tenderness and swelling over the flexor carpi radialis.[5] Pain is accentuated with passive wrist dorsiflexion.

Treatment involves appropriate work restrictions, immobilization, therapy, nonsteroidal anti-inflammatory medication, and occasional steroid injections. Typically, surgery does not play a common role in this condition.

First carpometacarpal joint osteoarthritis. This condition involves tenderness at the base of the first metacarpal.[6] It commonly attacks females in middle age. A positive grind test (axial compression of the first metacarpal against the trapezium) accentuates the patient's pain. Radiographic studies can confirm the diagnosis.

Treatment is conservative with surgery reserved for refractory cases.

Occult scaphoid fracture. Patients who have pain localized to the snuff box region between the extensor pollicis longus and extensor pollicis brevis may have an occult scaphoid fracture.[7] Typically, these patients are seen initially after a minor wrist sprain in which radiography did not show evidence of a fracture. Repeated roentgenograms or a bone scan 1 or 2 weeks later, however, may show a fracture through the scaphoid. If a fracture is detected, referral to a hand or orthopaedic surgeon is warranted.

Intersection syndrome.[8] Pain, swelling, and tenderness at the level of the muscle bellies of the abductor pollicis longus and extensor pollicis brevis, as they cross the radial wrist extensors, is known as an intersection syndrome. This occurs roughly 4 cm proximal to the wrist joint. The actual cause of pain is related to synovitis locally or in the second fibro-osseous extensor compartment of the wrist.

Treatment involves restriction of activities, splints, anti-inflammatory medication, steroid injection, and therapy.

Radial sensory nerve entrapment. The superficial radial nerve can be entrapped between the brachioradialis and the extensor carpi radialis longus, as it surfaces in the distal third of the forearm.[9] Patients have pain or numbness over the dorsal radial aspect of the wrist. Often, there is a history of trauma or repetitive supination and pronation movements. A positive Tinel sign is noted over the location of nerve entrapment. Symptoms may be provoked by a sustained hyperpronation position where the brachioradialis and extensor carpi radialis longus constrict the nerve.

Treatment involves avoidance of constricting jewelry, splinting, therapy, anti-inflammatory medications, and surgery for the refractory cases.

Ulnar wrist pain

Extensor carpi ulnaris (ECU) tendinitis/subluxation.[10] The ECU lies in its own fibrous tunnel on the ulnar side of the wrist, dorsal to the ulnar head. Tendinitis in this location can occur from repetitive motion while direct trauma can result in subluxation. The patient complains of pain, swelling, and sometimes of a palpable click.

In the acute case, treatment is directed at immobilization in a long arm splint, NSAID and steroid injections. When pain or subluxation persists, referral is warranted for possible surgical decompression or reconstruction.

Triangulo fibrocartilage (TFC) tears.[11] The TFC is a homogenous ligamentous and cartilaginous structure composed of the articular disk, radioulnar ligaments, the meniscus homologue, ulnar collateral ligament, and the sheath of the ECU. It functions both as a cushion for the ulnar carpus and a stabilizer of the distal radioulnar joint. Tears of this complex present with pain, clicking, and sometimes instability to the end of the ulna. Radiographs are not of value, except for assessing the relative length of the ulna to the radius (ulnar variance). Symptoms are more common when an ulnar positive variance exists, ie, when the ulna is longer than the radius. This leads to compression of the TFC between the distal ulna and the carpus. Arthrography is a reliable method of detecting TFC tears. If a symptomatic tear exists, referral is necessary for excision of the cartilage.

There are many additional causes of pain in the hand and forearm but the above conditions are common and present difficulties in diagnosis and treatment. Early recognition and appropriate aggressive treatment can shorten the period of disability for the injured worker.

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Fibromuscular pain disorders in the injured worker: accurate examination is the key to diagnosis

J. T. Harrington, MD, Madison

Fibromuscular pain disorders often present problems with diagnosis, management, and disability determination in injured workers. Medical knowledge about these common problems has increased, and accurate diagnosis and treatment are possible. The key to diagnosis lies in recognizing the patterns of pain produced by soft-tissue pain disorders, and in identifying characteristic physical findings. Laboratory and imaging studies are not helpful, and should be used judiciously when examination findings provide a basis for considering other conditions.

Unfortunately, many physicians have not been provided with information about fibromyalgia and myofascial pain in their training and postgraduate education. This contributes to delays in diagnosis and treatment, prolongation of worker incapacity, and often avoidable controversies in the determination of temporary and permanent disability.

The concept of pain arising from the soft tissues of the musculoskeletal system is nothing new to medicine. It was described in the European medical literature before the turn of the century. In 1938, Kellgren produced referred pain patterns by deep intramuscular injection of hypertonic saline.[1] In 1952, Travell and Rinzler published the first summary of the specific pain patterns referred from tender points in commonly involved muscles.[2] In 1989, a committee of the American College of Rheumatology reported criteria for the diagnosis of fibromyalgia,[3] and a review of fibromyalgia and myofascial pain by Robert Bennett, MD, is included in the most recent *Textbook of Rheumatology*.[4] In the last several years the term "fibromyalgia" has gained preference over "fibrositis" in identifying this condition.

Despite the awareness of myofascial pain and fibromyalgia among "pain experts," these concepts are still not commonly understood and used by many physicians. This too often leads to delayed diagnosis, treatment, and recovery, as well as to unnecessary and expensive diagnostic studies.

Fibromyalgia and myofascial pain are common sources of disability in workers with musculoskeletal injuries. It is important that physicians diagnose these problems accurately to promote optimal treatment and to help patients return to productive work.

Characteristics

Fibromyalgia most commonly affects women between the ages of 25 and 45, but may occur in children and older people. The symptoms of this disorder are muscular pain, stiffness, fatigue, and an interruptive sleep pattern. A few patients complain of joint pain, and true synovitis has never been associated with fibromyalgia. The characteristic diagnostic finding of fibromyalgia is the presence of tender points in characteristic locations within the muscles and periarticular tissues.

While pain is the most common symptom, some patients may complain of fatigue. Many of those diagnosed as chronic fatigue syndrome have fibromyalgia. Patients seldom volunteer information on abnormal sleep patterns, but when questioned directly they may report frequent sleep interruption, waking unrefreshed, and disruption of a spouse's rest.

Myofascial pain syndromes are characterized by deep, palpable trigger points in the muscles, but involvement is generally restricted to one or a cluster of associated muscle groups rather than being generalized. Fatigue and abnormal sleep are not characteristic, and the problem is more commonly triggered by injury or muscular overuse.

Tender or trigger points in these disorders tend to be associated with palpable "knots" in the involved muscle, with taut bands, and with tightness and reflex contraction of the involved muscle. Pain is referred from the trigger points, and the patient may not be aware of the site of origin. Symptoms may mimic nerve root injury and other musculoskeletal conditions.

The distinctions between fibromyalgia and myofascial pain disorders may be blurred due to coexistence in some individuals. A myofascial pain disorder induced by musculoskeletal injury may evolve into a more generalized fibromyalgia with associated sleep problems. People with fibromyalgia may have worsening of this problem by injury, physical fatigue, or muscular overuse, and they may develop a superimposed regional myofascial pain problem on top of longstanding fibromyalgia. Careful history-taking and definition of the distribution of pain are necessary to unravel these relationships.

The key to diagnosis

The diagnosis of fibromyalgia and myofascial pain depends on obtaining a careful history, and physical examination of the musculoskeletal system. In history-taking, the physician should determine where pain is located, whether joint pain and swelling exists, when and how the pain began, and what factors worsen it.

Joint examination shows no swelling or tenderness. The problems are in the muscles and muscular attachments. With proper technique, characteristic tender points can be identified in the cervical paraspinous, trapezius, pectoral, and upper gluteal muscles, as well as over the lateral epicondyles, near the greater trochanters, near the anserine bursae of the knees, and at the top of the achilles tendons. Pressure over these areas must be interspersed with examination of control areas in bony prominence to

verify the specificity of the finding.

Several examinations may be necessary to confirm the diagnosis since tenderness may vary with time, but the diagnosis should not be made unless trigger points are demonstrated or if the pattern of tenderness is atypical or bizarre.

Many physicians arrive at a possible diagnosis of fibromyalgia by a process of exclusion after first considering herniated disc, neurologic disorders, and internal diseases. This is often unnecessary and expensive, because the careful physical exam can make a positive diagnosis of fibromyalgia while at the same time show no positive neurologic or internal findings. Myofascial pain and other problems, however, are also not mutually exclusive.

Muscule pain and emotions

The belief is held by many physicians that fibromyalgia and myofascial pain are "psychogenic" in origin, or at least strongly related to emotional stress and depression. Studies of these pain disorders show that this is not the case. Psychogenic pain is not a common problem; it is variable, often bizarre, and cannot be verified by physical examination.

Fibromyalgia and myofascial pain as such do not share these characteristics. Several studies have shown that only a minority of fibromyalgia patients have psychological disorders. In some of these patients, however, emotional problems may result from chronic pain, disability, litigation, or delayed and conflicting diagnostic opinions provided by multiple physicians. In these individuals, features of chronic pain behavior may become prominent. The emotionally impaired patient with these disorders does pose special challenges in diagnosis and treatment, but the existence of these individuals should not be taken as evidence for a cause-and-effect relationship between emotional problems and fibromyalgia.

The disabled worker

The management of fibromuscular pain disorders presents a special challenge to the physician in the context of work injury and disability. At the same time, the physician plays the pivotal role in minimizing conjecture, misunderstanding, and financial loss for both the employer and the worker.

This role begins with the initial treating physician, ideally the patient's primary physician. Documentation of the initial symptoms, the circumstances causing them, any prior similar symptoms, and a careful examination are critical. Separation of myofascial pain from other problems–that is accurate diagnosis–and prompt referral when symptoms and disability do not resolve as expected in soft tissue injuries are critical.

Consulting physicians–neurologists, neurosurgeons, orthopedists, rheumatologists, or physiatrists–need to be versed in fibromyalgia and myofascial pain disor-

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ders as causes of musculoskeletal pain. The failure to make an accurate and prompt diagnosis, a bias against the validity of these problems, and performing extended studies for other disorders that are not suggested by physical examination may rapidly escalate the problems of pain and prolong disability. Work capacities and psychological evaluations should be ordered when appropriate.

Physicians also can be helpful in distinguishing treatments that are rational from those procedures offering no real hope of benefiting or resolving persistent pain problems.

Finally, physicians play a critical role by providing information in a timely fashion to the other parties involved in the workers compensation process. If this is done, then the patient's disability should be better understood and more accurately handled by the employer and insurance carrier.

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Assessment of disability status: the role of the physician

Sridhar V. Vasudevan, MD, Milwaukee

Physicians play the important role of communicating the status of the injured worker to the employer and the Division of Worker's Compensation. Generally, two major classes of disability are recognized: temporary and permanent.

Temporary disability

Most Worker's Compensation cases initially fall into the category of temporary total and temporary partial disability. This covers the period after the injury in which treatment is provided and healing occurs.

It is important for all parties involved in the Worker's Compensation system, to help return the injured worker to his employment as soon as possible. Eligibility for temporary disability benefits is determined, and must be managed, by the physician. Most employers have become aware of the advantages of early return to work, even if in a limited capacity.

During the time of active medical treatment, the patient is in a period of "temporary total disability." If the physician determines the appropriate medical restrictions, it allows the employer an opportunity to design suitable work, if available, for the injured worker. If no suitable work is available at that time, temporary total disability benefits are continued.

When the employee returns to employment in a limited capacity, such as limited number of hours, the patient is in the phase of "temporary partial disability." Physicians should have open communication with the employer whenever possible, so as to recognize those opportunities where a patient can return to part-time work. In this regard, it is important for the physician not only to identify those restrictions the patient should have, but also identify those capabilities that the patient has.

Permanent disability

When the employee/patient's condition has leveled off, and the prospect of future improvement is unlikely, the physician

Continued on next page

Factors addressed in a disability evaluation.

- History of the injury and subsequent treatment.
- Relationship of injury to the medical diagnosis.
- Any pre-existing disability.
- Medical diagnosis.
- Objective findings supporting the diagnosis.
- Period of temporary total disability during which patient is off work.
- Has the patient reached a "healing plateau"?
- Date the patient will be able to return to work. If the patient is unable to return to full duty work, when the patient may return to work part time or with limitations.
- Description of permanent impairments and the limitations.
- Descriptions of those functions the patient may be able to perform, ie, work abilities.
- Prognosis.
- Suggestions for future treatments, including vocational rehabilitation, equipment, environmental modification or future medical needs.
- Percentage of permanent partial disability using the scheduled or non-scheduled injury guidelines.

Dr Vasudevan is a member of the SMS ad hoc Committee on Pain and Disability. Reprint requests to: Sridhar V. Vasudevan, MD, 19333 W North Ave, Brookfield, WI 53045-4198.
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Continued from preceding page
determines that a "healing plateau has been reached." The patient is then evaluated for any residual permanent disability. Only on rare occasions is the patient "permanently and totally disabled" for all work.

In some situations, the patient is left with certain residuals or limitations after the injury or illness reaches the healing plateau. These patients are evaluated for "permanent partial disability" (PPD). This applies to a loss due to physical capacity, mental capacity, or particular body part(s) after an injury or disease has reached a plateau. Injured workers may be capable of returning to their previous employment or may return to some other type of employment within their functional capabilities and limitations. Permanent partial disabilities may also include potential or actual loss of earning capacity.

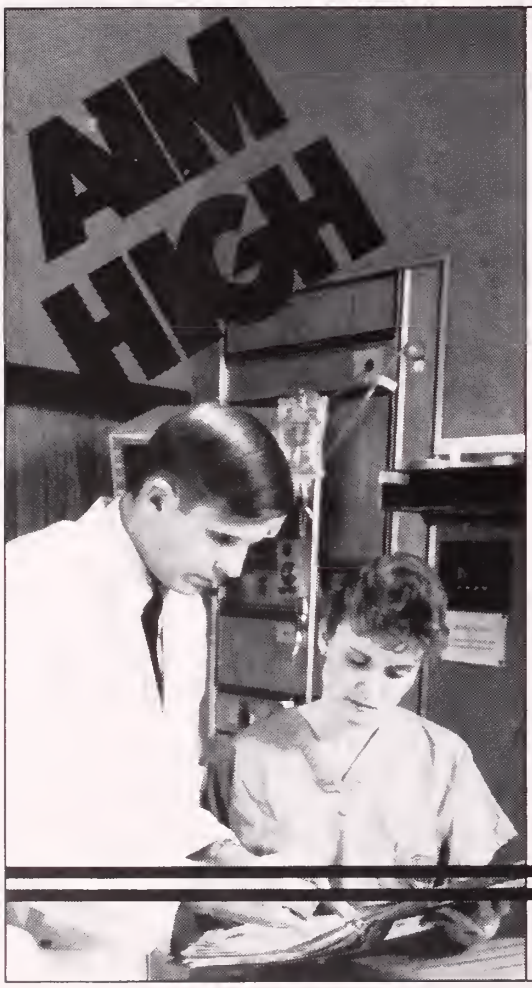
The assessment of permanent partial disability can either be done on either a scheduled or non-scheduled basis.

Scheduled injuries. The Wisconsin Worker's Compensation law sets a schedule of various kinds of injuries for which a corresponding number of weeks worth of pay as benefits are allowed. Examples include injuries to extremities, eyes, and hearing. For scheduled permanent partial disability ratings of extremities, the law requires that the degree of disability or loss of function should be compared to amputation of the affected or nearest joint. For example, total knee replacement is scheduled to be a 40% loss compared to amputation at the knee. The Wisconsin Worker's Compensation Division can be contacted to obtain the schedule for permanent disabilities.

Non-scheduled injuries. For permanent injuries that are not listed on the schedule of injuries, such as injuries to the head, spine or torso, a medical estimate must be made as to the amount of permanent loss. These non-scheduled injuries must also take into account the employee's ability to perform in the labor market after the injury. These permanent partial disability ratings are generally compared to the body as a whole being 100%, rather than to a specific joint or function.

Disability evaluation. Permanent partial disability is reported on the Worker's Compensation Division WC-16 and WC-16B forms. This form is sent to the physician by the insurance carrier or employer, which then forwards a copy to the Worker's Compensation Division, where it is the only record on which the amount of compensation for permanent disability is made. Proper completion of the entire form will benefit all parties and expedite payments to the injured employee, as well as the physician.

Evaluation of disability is a highly complex process, confusing both to the



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patient and the physician involved. Many elements of disability are subjective and therefore, not capable of being measured precisely. Pain, dizziness, paresthesia, and fatigue are examples of symptoms that are difficult to quantify but may be quite disabling.

It is recognized that the current available methods of physician assessment are not always adequate and complete. Nevertheless, in the best of the physician's judgement, specific activities that the patient should avoid should be clearly identified. Delays and confusion in determining permanent disability leads to hardship for the injured worker, the employer, the physician and the insurance industry.

The physician should, in his notes or report, address the questions in the Table.

Conclusion

Successful rehabilitation of injured workers requires active cooperation between the physician, the Worker's Compensation Division, employer, injured worker and the insurance company. Other parties involved, such as attorneys, case managers, and other rehabilitation professionals need to communicate promptly and appropriately. This paper has provided some of the basic knowledge and mechanisms for optimal delivery of services to the injured worker.

Prompt, accurate, objective reporting by the physician with the details that were described in an earlier article should facilitate early return to work and avoid chronic disabilities.

Special publications such as "Guide to Wisconsin Doctors using the WC-16B Form," and "How to Evaluate Permanent Disability" is available through the Worker's Compensation Division. Write to: Worker's Compensation Division, Room 161, PO Box 7901, Madison, WI 53707 or telephone (608) 266-1340.[15pts]

Review process for reasonableness of fees and necessity of treatment disputes involving Worker's Compensation cases

Cecilia Geis, SMS health policy analyst

THE FOLLOWING OVERVIEW of the Worker's Compensation resolution process for reasonableness of fees and necessity of treatment has been modified from materials prepared by the Worker's Compensation Division of the Wisconsin Department of Industry, Labor, and Human Relations (DILHR).

DILHR, the state department responsible for regulating Worker's Compensation, has established a new appeals mechanism for Worker's Compensation-related disputes concerning both reasonableness of fees and necessity of treatment. Since 1985, under the Worker's Compensation system, if there were no other issues in dispute, DILHR resolved disputes between providers and insurers regarding the cost of health care provided to injured workers without a hearing by reviewing written material submitted by both parties. In 1990, DILHR began a similar review process for disputes over the necessity of treatment. Responding in part to concerns voiced by Worker's Compensation providers, DILHR worked with the SMS and others to develop an appeals process which became part of the Worker's Compensation Advisory Council's recommendations.

Legislation enacted in 1991 significantly changed the review process for both cost and necessity of treatment disputes. The necessity of treatment dispute process changes became effective for treatment provided on or after Jan 1, 1992. The cost dispute process changes became effective for treatment provided on or after July 1, 1992. It is the date of treatment, not the date of injury, that determines whether the new process will be used. The summary below provides an outline of the current appeals mechanism for disputes concerning both reasonableness of fees and necessity of treatment.

Necessity of treatment

Under the Worker's Compensation law, when a Worker's Compensation insurance carrier or self-insured employer questions the necessity of the treatment rendered and refuses to pay part or all of a medical bill it must give written notice to the health service provider explaining why the bill is denied. A health service provider or provider includes a physician, podiatrist, psychologist, optometrist, chiropractor, dentist, physician's assistant, therapist, medical technician, or hospital. The insurer's notice must be given within 60 days of receiving the bill unless DILHR authorizes an additional 60 days to obtain supporting medical documentation.

The provider has 9 months from the date it receives notice to apply to DILHR for a review of the dispute; but at least 30 days prior to submitting a dispute to DILHR, the provider must give the insurer a written explanation regarding why the treatment was necessary to cure and relieve the effects of the injury. The explanation given by the provider must include a diagnosis of the condition for

Continued on next page

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which treatment was provided. If the dispute is not resolved within the 30-day waiting period, the provider may then apply to DILHR and must send a copy of all material to the insurer.

When a necessity dispute is submitted, DILHR will notify the insurer or self-insurer that it has 20 days to pay the bill or file a written answer. The answer must include the name of the organization, and the credentials of any individual, whose review of the case has been relied on in denying payment.

When the 20-day period to answer has elapsed, DILHR will submit the dispute to a health care expert licensed in the same profession as the individual provider whose treatment is under review. The expert will be selected by an independent, impartial, health care review organization, under contract to DILHR, or by DILHR from a panel of experts selected to conduct these reviews. The expert will render an opinion within 90 days.

The insurer and provider have 20 days to provide clear and convincing evidence that DILHR's expert is wrong. DILHR will then adopt or modify the expert's opinion, determine the losing party, and issue an order. The order may be appealed to circuit court.

For each dispute, DILHR will charge one of the parties for the actual costs of obtaining the expert's opinion. Under the law, the insurer is responsible for paying the full cost the first time an individual health care provider submits a dispute unless DILHR determines that the health care provider's position is frivolous or based on fraudulent representations. In any subsequent dispute involving that health care provider, the losing party–provider or insurer–must pay the full cost of obtaining the expert's opinion.

Under the current Worker's Compensation law, you may not collect a fee for the disputed treatment from, or bring an action for collection of the fee for that disputed treatment against, the employee who received the treatment.

If the injury or claim is at issue in a Worker's Compensation case and an application for hearing is filed, DILHR may delay resolution of the dispute until a hearing is held or an order is issued resolving the dispute between the injured employee and the Worker's Compensation carrier or self-insured employer.

Reasonableness of fees

Effective July 1, 1992, DILHR will certify one or more data bases that list fees charged by providers. The fees will be sorted by CPT code. Each certified data base will list a dollar amount (called the "formula amount") for each CPT code. The formula amount is the arithmetic mean of all the fees in the data base, plus 1.5 standard deviations from the mean, in a particular region of the state, for a specific CPT code. For example, if all provider charges in the data base for a certain medical procedure were represented by a perfect, bell-shaped curve, the formula amount (that is, 1.5 standard deviations from the mean) would be at approximately the 93rd percentile.

Within 30 days of receiving a bill that is beyond the formula amount in the data base for that procedure, the Worker's Compensation insurance carrier or self-insured employer must notify the provider that it is disputing the fee. To make sure there is no misunderstanding between the provider and the insurer, the insurer's notice to the provider disputing the fee must specify the name of the patient, the employer, the date of the procedure in dispute, the amount charged, the CPT code, the formula amount for that code, the data base from which it was taken, and the amount in dispute. The

Table 1.–Review procedure for necessity of treatment disputes.

- Medical care is provided and the bill for services, which adequately documents the treatment provided, is submitted to the Worker's Compensation carrier for payment. Adequate documentation is the HCFA 1500 (12-90) form completed with ICD-9 and CPT-4 codes to describe the diagnoses and treatment.
- The Worker's Compensation carrier reviews the bill for necessity of treatment.
- The bill is either approved for payment or the Worker's Compensation carrier notifies the provider with a written explanation as to why bill is denied. Notification to the provider must be given within 60 days of the carrier's receipt of the bill unless DILHR authorizes an additional 60 days.
- The provider accepts the Worker's Compensation carrier's explanation or submits written documentation to the carrier why the treatment was necessary. The written documentation must be submitted to the carrier at least 30 days prior to continuing forward to the next step in the dispute process.
- If the Worker's Compensation carrier continues to dispute the necessity of treatment, the provider may submit the claim dispute to DILHR. The provider has 9 months from the date it receives notice from the carrier to apply to DILHR for a review of the dispute.
- DILHR will notify the Worker's Compensation carrier to pay the claim or file a written explanation. The carrier has 20 days to respond to DILHR.
- When the 20 day period to answer has elapsed, DILHR will submit the dispute to a health care expert for an opinion. (Currently, DILHR contracts with WIPRO for expert medical review.)
- The medical review expert will render an opinion within 90 days.
- Both the Worker's Compensation carrier and the provider have 20 days to provide evidence that the medical review expert's opinion is wrong.
- DILHR will adopt, modify or accept the medical review expert's opinion.
- DILHR will determine the losing party and issue an order.
- The losing party, either the Worker's Compensation carrier or the provider, will be charged for the cost of obtaining the medical expert's opinion. Under the law, the carrier is responsible for paying the cost for medical expert opinion the first time an individual health care provider submits a dispute unless DILHR determines that the provider's position is frivolous or based on fraudulent representation.
- Either the Worker's Compensation carrier or the provider may appeal the decision to circuit court.

insurer's notice must also explain the process that the provider would use to justify a fee more than the formula amount if the service was more difficult or complicated than usual. The insurer must also

Continued on next page

Table 2.–Review procedure for reasonableness of fees disputes.

- Medical care is provided and the bill for services is submitted to the Worker's Compensation carrier for payment.
- The Worker's Compensation carrier reviews the bill to determine if the fee is over the formula amount.
- If the bill is less than the formula amount for that CPT code in a certified database the bill should be paid by the Worker's Compensation carrier. If the bill is more than the formula amount the carrier must notify the provider within 30 days of receiving the bill that it is disputing the fee. The insurer, however, must pay the non-disputed amount of the fee to the provider within this time.
- The provider accepts the formula amount or submits written documentation to the Worker's Compensation carrier why the treatment was more difficult or complicated. The written documentation must be submitted to the carrier at least 20 days prior to continuing forward to the next step in the dispute process.
- Within 15 days of receiving the justification for a higher fee from the provider, the Worker's Compensation carrier must either pay the fee or explain it's continuing refusal to pay.
- The provider has 6 months after the Worker's Compensation carrier first refuses to pay the disputed amount in which to file a request for DILHR to resolve the dispute.
- When a fee dispute is received by DILHR, it will notify the Worker's Compensation carrier that it has 20 days to pay the bill or file a written answer. If the carrier does neither, a default judgement will be ordered.
- Either the Worker's Compensation carrier or the provider may appeal the decision to circuit court.

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Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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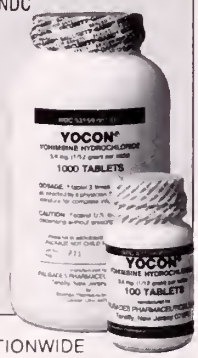

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pay the non-disputed amount of the fee to the provider at this time.

A fee less than the formula amount is considered reasonable by DILHR. A fee more than the formula amount is considered unreasonable unless the health service provider proves to the satisfaction of DILHR that a higher fee is justified because the service provided in the disputed case was "more difficult or more complicated than in the usual case."

The provider has 6 months after the insurer first refuses to pay the disputed amount in which to file a request for DILHR to resolve the dispute. DILHR will not, however, review the dispute unless, at least 20 days before submitting a fee dispute to DILHR, the provider explains to the insurer, in writing, why the procedure was a more difficult or complicated than usual. Within 15 days of receiving the justification for a higher fee, the insurer must either pay the fee or explain its continuing refusal to pay.

When a fee dispute is submitted to DILHR, it will notify the insurer that it has 20 days to pay the bill or file a written answer. If the insurer does neither, a default judgment will be ordered.

If the insurer misses any deadline for responding, it shall pay 12% annual interest from the date of the missed deadline to the date of actual payment to the provider under the late claims statute for insurance carriers.

Within 90 days of receiving the insurer's answer, DILHR will issue an order resolving the dispute. Either party may appeal the order directly to circuit court.

Under the Worker's Compensation law, you may not collect the disputed fee from, or bring an action for collection of the fee against, the employee who received the treatment.

If the injury or claim is at issue in a Worker's Compensation case and an application for hearing is filed, DILHR may delay resolution of the dispute until a hearing is held or an order is issued resolving the dispute between the injured employee and the Worker's Compensation carrier or self-insured employer.

The SMS worked with the Worker's Compensation Division and the Worker's Compensation Advisory Council to develop fair and equitable review processes for disputes concerning reasonableness of fees and necessity of treatment and physicians are encouraged to work with the established dispute resolution processes. The SMS will continuously monitor the effectiveness of these review processes, and any physician with concerns regarding specific cases that he or she believes are not being appropriately handled by this new system should call the SMS or submit written materials to the SMS office.

Physicians and the Worker's Compensation System

Sridhar V. Vasudevan, MD, Milwaukee

At one time or another, many Wisconsin physicians will become involved with patients who have been injured or become ill due to work-related injuries or exposure. These physicians play a major role in the successful delivery of services to these injured workers.

"Injury" is defined by Wisconsin's Worker's Compensation law as mental or physical harm to an employee caused by accident or disease, including mental harm or emotional stress or strain without physical trauma, if it arises from exposure to conditions or circumstances beyond those common to occupational or non-occupational life (Table 1).

Eligibility for Worker's Compensation benefits are determined by the physician. In acute injuries arising from a traumatic incident at work, direct causation is easy to determine. For a disease process, however, the determinations are more difficult. The connection between a disease and employment is heavily dependent on assessment of the worker's "degree of exposure" to a particular chemical or physical agent, or an ergonomic stressor. Physicians and employers should, and can, work together to provide pertinent information about work history, and the specific job the worker was performing when injured. It is important for the physician to be independent, scientific, and objective in his evaluation and assure prompt and regular payment of benefits to the worker. Such benefits reduce the injured worker's anxiety, promote healing, and assist in a successful and early return to work.

Table 1.–Essential features of the Worker's Compensation System.

- Provide benefits for patients with injuries or illnesses related to employment.
- Financial coverage for health care expenses.
- Payment for temporary loss of wages.
- Payment for permanent loss of functional ability and earning capacity.

The physician's decision regarding work relatedness, diagnosis, and initial treatment, is conveyed to the Worker's Compensation Division through a variety of forms The Physician's First Report

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form, completed at the initial visit, should include information on work-relatedness, and provide notification of injury or illness to the Worker's Compensation insurance carrier, while meeting OSHA reporting requirements. The WC-16B form titled, "Practitioner's Report on Accident or Industrial Disease in Lieu of Testimony," often completed at the final visit when residual permanent disability can be assessed, is a major mechanism of communication between the physician and the Worker's Compensation Division. The SMS *Wisconsin Occupational Health Guides* provides additional detailed information regarding these forms. Further questions can be answered by contacting the SMS.

During initial contact with the injured worker, the physician should be sure to obtain certain crucial pieces of information (Table 2). Documentation of these details saves time in completion of the more complex WC-16B form later. The physician's initial consultation and office notes can be attached to the WC-16B form in communicating with the Worker's Compensation Division.

The major theme of this series of articles is to prevent chronicity in work-related injuries or illnesses. It is important for the physician to differentiate between acute pain and chronic pain.

Acute pain is of recent onset (usually less than 10 days) or may be intermittent and recurring. There is usually a biologic or tissue damage component that is dominant. Acute pain subsides in less than 6 months–usually less than 30 days. Acute pain is biologically useful, usually associated with identifiable focal tissue pathology or disease, and is self-limited.

Chronic pain is pain that lasts beyond the healing period, usually longer than 6 months, with minimal or no objective physical findings of residual structural defect. Despite numerous investigations, there is no clearly identifiable or treatable medical or surgical pathology. Chronic pain can become a major focus of the patient's life, leading to significant lifestyle changes, characterized by the following: drug misuse (especially narcotics and tranquilizers); deconditioning; disuse and dysfunction; depression (usually characterized by physical and social withdrawal, sleep disturbances, irritability and weight gain); and disability (especially in regards to work) that far exceeds the underlying objective findings.

Chronic pain needs to be managed using a interdisciplinary psychophysiological approach emphasizing education and decreasing attention to pain behaviors and encouraging well behavior, avoiding narcotic medications, increasing physical activities, treating the associated depressive symptoms, and returning patients to productive work.

Table 2.–Essential elements to document in work-related injuries.

- Name, sex, and age of employee.
- Name of the employer.
- Date of accident or if illness, last day of work.
- Description, in the patient's words, as to the work exposure to which the patient attributes the condition for which he is seeking attention.
- Chief complaint, history of present illness, and the appropriate objective physical findings to support the diagnosis.
- Date patient was first seen (and all subsequent examination dates).
- If patient was asked to stay off work, date disability from work began.
- Any comments regarding expected duration of impairment, and anticipated time of healing or recovery.
- The ability of the patient to perform limited or alternate work, and if so, when.
- Any information that the physician believes contributes to the work-relatedness of the injury or illness, either by direct causation, or by work exposure aggravating or accelerating any pre-existing condition(s).*

If the major symptom is that of pain, then the following should be noted:

- Intensity of pain–an attempt to subjectively gauge the pain using a 0-10 scale, where 0 is no pain and 10 is unbearable pain. This should be noted on repeat examinations to have some elements of objectifying the patient's subjective pain experience.
- Location of pain.
- Character and description of the pain (burning, throbbing, aching, shooting or other).
- Associated sensory or sympathetic symptoms–tingling or numbness? coldness? increased sweating?
- Aggravating and relieving factors.
- Response to treatment and the temporal nature of pain.
- Is the pain consistent with underlying anatomical and physiological findings or disease? Is it exaggerated? Is it non-physiological?
- Effects of pain on the patient's psychological functioning–increased anxiety, depression, or withdrawal?
- Episodic pain symptoms, such as with headaches or with soft tissue pain–inquire about frequency and duration of symptoms.
- Effect on patient's daily activities, family, and any relationship to work activities.
- In all patients, attempt to have an objective examination of the following:
- Joint range of motion, both actively and passively.
- Neurological changes such as sensory loss, motor weakness or reflex alterations, radiological findings, and any other electrodiagnostic studies or laboratory abnormalities. In soft tissue symptoms, note any objective swelling or edema, warmth, deformity, atrophy, or consistent and reproducible tenderness.
- Muscular strength of involved or nearby structures.

*Please note that the employee's history may be inaccurate or incomplete. The physician is expected to render an independent medical opinion on causation, and should note information supporting his determination of work-relatedness.

Conclusion

Physicians play a key role in promptly diagnosing, selecting and providing appropriate treatment, and in communicating the status of the injured worker to the Wisconsin Worker's Compensation Division. This article has highlighted the benefits provided to the injured worker, emphasized the specific elements to be included in documentation by the physician who cares for the injured worker, and finally, provides differentiation between acute and chronic pain.[15DH]

Public health

Breast cancer survival in Wisconsin

Paula M. Lantz, PhD; Patrick L. Remington, MD; and Barthelemy Kuate Defo, PhD, Madison

BREAST CANCER is the most common kind of malignancy diagnosed among Wisconsin women, and continues to be the leading cause of female cancer mortality in the state. As part of a public health agency initiative grant from the National Cancer Institute ("Data-Based Interventions in Cancer Control"),[1] we conducted a population-based survival analysis of Wisconsin women diagnosed with breast cancer. The purpose of this study is to compare breast cancer survival experience in Wisconsin with the rest of the United States and to provide a baseline for monitoring progress in breast cancer control in Wisconsin.

All female Wisconsin residents diagnosed with cancer of the breast (ICD-9 174-175) during 1981 and reported to the Wisconsin Cancer Reporting System were selected for the study. Information from the Wisconsin Death Registration System was searched for the years 1981 through 1988 to identify study patients who died within 7 years of their diagnosis. For cases where a death certificate was found, information regarding the date of death and the cause of death was merged with the incidence data.

We also conducted a nationwide search for death certificate information using the National Death Index, National Center for Health Statistics. The National Death Index is a centralized file of identifying information on all deaths occurring in the United States since 1979.[2] A computerized file of cases that did not have a Wisconsin death certificate on record was sent to the National Death Index to determine if any of the women had died elsewhere in the United States from 1981 through 1988. Subsequently, the National Death Index produced a list of possible matches with death certificate data, including the name and birthdate of the deceased, the date of death, the state of death, and the death certificate number.

The mortality data were used to estimate crude and relative survival rates, using the methodology recommended by the National Cancer Institute.[3] A relative survival rate adjusts the observed or crude survival rate for expected age-specific mortality, representing the likelihood that a patient will not die from causes associated with their cancer during a specified period after diagnosis. Five-year and 7-year relative survival rates for Wisconsin 1981 breast cancer patients were compared with national survival rates for 1981 patients, as reported by the Surveillance, Epidemiology and End Results (SEER) program in an annual publication.[4]

All follow-up information was obtained from death certificates. We did not contact patients, their families or their physicians for any additional information. The study protocol was approved by the University of Wisconsin-Madison Center for Health Sciences Human Subjects Committee and by the National Death Index Advisory Board.

Results

There were 2,163 cases of female breast cancer diagnosed in Wisconsin in 1981. The average age of the patients at diagnosis was 64 years. Approximately half of the cases in which the extent of disease at

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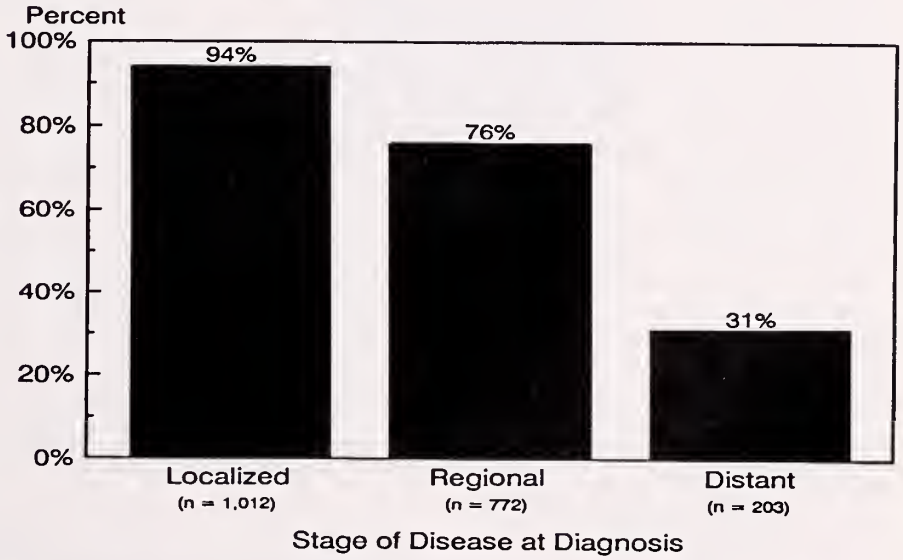

Fig.–Five-year relative survival rate by stage of disease at diagnosis, Wisconsin women diagnosed with breast cancer, 1981.

The public health column is not reviewed by the *WMJ* editorial board. Dr Lantz is a senior researcher at Marshfield Medical Research Foundation, a division of Marshfield Clinic. Dr Remington is chief medical officer and medical epidemiologist with the Wisconsin Division of Health, Bureau of Public Health. Dr Defo is a demographer and recent graduate of the University of Wisconsin-Madison. This research was supported by a grant that the Wisconsin Department of Health and Social Services received from the National Cancer Institute (R01-CA46883). Reprint requests to: Patrick L. Remington, MD, 1400 E. Washington Ave, Madison, WI 53703-3041. Copyright 1992 by the State Medical Society of Wisconsin

Continued from preceding page
diagnosis was documented (92% of sample) were detected at an early stage: 2% of the cases were staged as in situ malignancies and 49% were localized to the breast. Another 39% of the cases had spread regionally (to axillary lymph nodes or to surrounding tissue by direct extension) and 10% had spread to distant organs (metastatic disease).

A total of 824 of the patients died within 7 years of diagnosis; 17 of these deaths were identified through the National Death Index matching process. The 5-year crude survival rate was 69%; the 7-year rate was 62%. For deaths occurring within 7 years of diagnosis, the underlying cause of death was distributed as follows: 61% breast cancer, 14% cardiovascular disease, 11% other cancer, 9% infectious/parasitic disease, and 5% other.

Relative survival rates (ie, crude survival corrected for expected mortality) for white women in Wisconsin and the United States are presented in the table. The 5-year and 7-year relative survival rates for Wisconsin women are higher than those for US women as a whole, as represented by the SEER data.

The figure displays the survival rates of patients by stage at diagnosis, relative to persons without breast cancer. While 94% of women whose cancer was found while localized to the breast were alive 5 years later. In contrast, only 31% of the women with distant spread or metastatic disease survived 5 years. Controlling for age at diagnosis and other sociodemographic variables, women diagnosed while the disease was still localized to the breast were 2.5 times as likely to survive 7 years than women whose cancer had spread regionally (95% confidence interval 1.8, 3.2), and were 8 times as likely to survive as women whose cancer had spread distantly at the time of detection (95% confidence interval 7.3, 8.7).

Based on these survival results, we estimate that if all Wisconsin women with breast cancer were diagnosed at an early stage there would be 300 fewer breast cancer deaths annually.

Survival rates for breast cancer for white women diagnosed in 1981.

	Wisconsin		Nation[3]
	Crude	Relative	Relative
5-year survival	69%	80%	76%
7-year survival	62%	77%	70%

[3]Data from National Cancer Institute Surveillance, Epidemiology and End Results Program.

Comment

Increased breast cancer survival has been associated with early detection of disease in previous population-based survival analyses.[5,6] Not surprisingly, the results presented here demonstrate that breast cancer survival is strongly related to stage of disease at diagnosis. In addition, the results also show that the relative survival rate for women with early stage disease does not decrease between 5 and 7 years. That is, 94% of the population expected to live 5 years after diagnosis does survive, and the survival rate remains the same at 7 years. This finding is important, as it suggests that the chance of surviving early stage breast cancer does not decrease between 5 and 7 years post-diagnosis.

Wisconsin breast cancer relative survival rates are slightly higher than the national rates, according to SEER data. The reasons for this difference are unknown. Likely explanations include higher rates of early detection or higher rates of treatment success in Wisconsin than the nation as a whole.

The women in this study were diagnosed with breast cancer in 1981, a time which predates the widespread use of mammography for breast cancer screening.[7] In 1981, 51% of breast cancer cases were diagnosed at an early stage. By 1990, this proportion had increased to 67%. With this shift toward earlier detection, the cohort survival rates for women currently diagnosed with breast cancer will likely be higher than those reported here. In turn, this shift should eventually lead to a decrease in breast cancer mortality.

In conclusion, Wisconsin women should be assured that breast cancer is not a fatal diagnosis, and that early detection through the use of mammography offers a great chance for recovery and survival. In fact, the results of this study demonstrate that if all Wisconsin women with breast cancer were diagnosed at an early stage through the use of screening mammography, the breast cancer mortality rate would be reduced by more than one third.

Acknowledgements

Jerri Linn Phillips, lead analyst for the Cancer Reporting System, provided the Wisconsin incidence and mortality data as well as technical assistance throughout the study. Peter Layde, MD, Douglas Reding, MD, Laurence Dupuis, and Judith Zvara reviewed the manuscript and provided helpful comments and suggestions.

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The Gundersen legacy

When Adolf Gundersen, MD, arrived in La Crosse from Norway, medical care in the area was little more than a carnival side show. It was April 1891, and the leading physician in town was a former attraction in the Buffalo Bill Cody Wild West Show who produced and sold patent medicines of which one advertisement claimed "magically relieves internal and external pains." These miracle cures were augmented by eclectics, homeopaths, naturopaths and some 30 physicians and surgeons, most of whom were products of apprenticeships or diploma mills. Dr Gundersen was about to change all that.

Dr Gundersen was a graduate of the Christiania Medical School, now the University of Oslo, where the education of physicians was far more rigorous, formal, academic and scientific than the training offered to most American doctors. In fact, he was among the 19th century waves of European immigrants seeking greater freedom in the United States, and part of the freedom he sought was the opportunity to practice medicine without fighting through the barriers presented by Norway's medical hierarchy. In La Crosse, Dr

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The Gundersen family: (l to r) Borge, Sig, Helga, Alf, Sven, little Helga, Thorolf, Gunnar, Adolf and Trygve. *Photo courtesy of the Gundersen Clinic.*

Gundersen was able to perform surgeries and pioneer procedures that would have been denied to him in his native land until he had gained years of seniority. It was this combination of American freedom and European standards of medical excellence that allowed Dr Gundersen to transform La Crosse with his particular brand of genius.

So profound was Dr Gundersen's effect on La Crosse that for years the normal life cycle in the area became known as birth, christening, an operation by Gundersen and death. Physicians in western Wisconsin, southeastern Minnesota and northeastern Iowa began sending their patients with the most difficult ailments to Dr Gundersen and his first partner, Dr Christian Christensen, a superb diagnostician.

The two physicians combined their complementary skills and opened an office above the Bellerue Drug Store in downtown La Crosse. A group practice of sorts, the Christensen and Gundersen Firm, was thus born.

Dr Gundersen's early claim to fame was his skill at performing appendectomies. He performed one of the first–if not *the* first–such operation in Wisconsin in the 1890s. In 1899, he delivered a paper on appendectomies to the Norwegian Medical Society, and in 1912, delivered a paper on his 100 consecutive successful appendectomies to the International Surgical Association. So powerful was Dr Gundersen's reputation for this procedure that physician would put their patients with "bellyaches" on a train for La Crosse; so often did this happen that the train, which stopped behind the Lutheran Hospital, became known as the Appendectomy Limited.

Of course, respect for Dr Gundersen was not universal. The "Yankees" of La Crosse would allow Dr Gundersen to care for their servants–*if* he entered through the back door–but not for themselves. For serious matters, they traveled to Minneapolis or Milwaukee. Impatient with such bigotry, Dr Gundersen once refused to make a house call to the home of one of the city's elite who had summoned him at night on behalf of a family member. When he would not change his mind, he was told that the sick family member was actually the family dog–to which he responded "I'll come right away." He even refused to wear the medal of Norway's Knight of the Order of St Olaf, deeming it undemocratic.

One of Dr Gundersen's sons, also a surgeon, once quipped that he could make

Adolf Gundersen, MD, (second from r) performing surgery with his associate, Christian Christensen, MD, (fourth from l). *Photo courtesy of the Gundersen Clinic.*

a good living tending only to the patients his father told off. It is true that he was a proud, even arrogant, man, but he had the skills to support his confidence. He could also be both overbearing and irritable. Nurses warned each other of his impending arrival on the hospital floor by tapping on the pipes, and student nurses reportedly hid in closets to avoid him. Eventually, his kindness, dedication and compassion for his patients, as well as his skill as a physician, earned him the respect of the hospital staff.

Another of La Crosse's elite described Dr Gundersen as one of "a breed of long-gone charismatic 19th century men.... Men scurried out of the way of these men because what they wanted, they were going to get-and what they said was going to go!"

Fear of Dr Gundersen was inspired in part by his no-nonsense demeanor, and part by his standards for the provision of health care. When he visited the hospital, he checked in on every patient, regardless of whether they were his, with a secretary in tow who carried the patient files for his quick reference. And when another La Crosse physician accidently put a scalpel through the eye of a patient, Dr Gundersen was so incensed that he demanded to have control over which physicians would practice at Lutheran Hospital. The hospital board agreed, and the lawsuit that followed produced a landmark decision by the Wisconsin Supreme Court, allowing hospitals to set standards their own medical staffs.

In 1938, Dr Gundersen and his wife, Helga, were making one of their almost annual trips to Norway when a kidney stone blocked his urinary tract and, ironically, the immediate surgery he needed was unavailable. Dr Gundersen's chapter in history ended there in the Norwegian mountains, but the effects of his life are still being felt.

Dr Gundersen can be credited for bringing modern medicine to La Crosse, for pioneering important surgical procedures, and for being an early advocate of quality assurance, but his greatest medical legacy may be his family. At last count, 21 children, grandchildren and great grandchildren of Adolf Gundersen were or are physicians (one of whom also served as president of the AMA). And the medical practice that bears his name, which celebrated its 100th anniversary last year, is now one of the largest multispecialty group practices in the nation and treasures a reputation for excellence that would have made Adolf proud.[15,16]

Lutheran Hospital (l) and Gundersen Clinic (r), circa 1930. *Photo courtesy of Gundersen Clinic.*

The Gundersen Clinic/Lutheran Hospital complex, as it stands today. *Photo courtesy of Gundersen Clinic.*

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A glimpse into our past

Richard Sautter, MD, medical editor

31 years ago

Cultural revolution. The times, they were a changin', as reflected by a *WMJ* article on the "Husband of the gynecologic patient." That husbands had become a concern for gynecologists was a sign of change in itself. The article, however, listed 10 classifications for "modern husbands." A few examples:

The "normally devoted" husband is interested in his wife's problems, accepts explanations of her illness, trusts the physician's judgment, and is confident that people respect him regardless of his station in life. The "organization man" is so anxious to climb the corporate ladder that any interference, including his wife's illness, is an unacceptable irritant. The "traveling man" is an overnight guest or weekend visitor in his own home. "He can stand just about 24 hours of nagging before crying for medical help." The "suspicious" husband sends his wife to a female physician because he does not want any other man looking at her.

When was this written? An editorial in the *WMJ* opened with a paragraph that could be transferred, with very little alteration, to today's pages:

"Picking on the AMA has become a popular indoor sport with that section of the American press that favors tax-supported medicine. As part of the effort to give color to the image of a service profession held in thrall by a 'trust' or 'union' controlled by ultra right-wing elements and semi-retired, wealthy, non-working 'political' doctors, the impression is conveyed that the average doctor doesn't dare disagree publicly for fear of being put out of business by 'Organized Medicine.'"

62 years ago

Before the rise of suburbs? An editorial in the *WMJ* had this to say about an article

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on the state of rural health care in Wisconsin: "Together with the essayist, we are disposed to believe there has been too much sympathy wasted on the woes of the modern country doctor. He has his share, of course, but as compared with the city physician who occupies a dingy flat in, or at the edge of, a city slum district, he certainly has no occasion to develop an 'inferiority complex.'" Today, of course, both the inner cities and rural areas suffer from physician shortages.

A novel approach to liability reform. The "solicitor of a large malpractice insurance company" asserted that:

"Seventy-five percent of all malpractice suits are started as counterclaims to suits by physicians to collect their bills. If physicians would only take the precaution of waiting the two years during which the statute of limitations runs on malpractice actions they would eliminate three out of four malpractice suits."

93 years ago

Say it ain't so, doc! Dr H. Reineking, of Sheboygan, delivered a presidential address at the annual meeting in which he commented on how well Wisconsin physicians were meeting the challenges laid out by the SMS constitution.

"The cultivation of harmony and good feeling among the members of a profession like our's is certainly a most commendable object. Yet it is unfortunately true that these conditions have not always prevailed, nor do they at the present time prevail, within the ranks of the medical fraternity, to the extent desirable among members of a learned and liberal profession. Doctors bear the opprobrium of being given to disagreeing, friction, and lack of sociability not undeservedly."

The tools of another day. Common treatments for pneumonia included: "Strychnin, caffein, camphor, alcohol, and spir. ammonia, as indications arise... When cough is harassing, or pain is robbing the patient of sleep, opium, in one form or other, may be given, but very circumspectly, if at all, to infants."

124 years ago

Birth of the 'shot.' There was considerable debate among physicians, including those at the SMS annual meeting, about "the hypodermic employment of medicine as another resource of our art." A committee formed by the SMS to study the innovation found that although it "would seem not to be wholly devoid of danger or unpleasant consequences ... This method of using medicines ... will soon come into general use."

Thinking can make you sick. Dr Waterhouse took issue with the prevailing notion that anemia in children was caused by "a deficiency of the volume of circulating fluid," and more correctly determined that one of the causes was a "deficiency in (the blood's) general amount or want of due proportion in the nutritive and stimulant ingredients." His explanation of how this nutrient shortage was created, however, was even more interesting: school work. Dr Waterhouse asserted that because the blood carries nutrients to fuel all organs, including the brain, the strenuous brain activity required of students ("more mental labor than most business men") overtaxes the blood's nutrient supply and causes anemia. "What else can you expect?" he wrote. "You cannot get more from the blood than there is in it."[150th]

Physician briefs

The * indicates a member of the SMS.

Wendell Dean Bell, MD, has joined the staff of Monroe Clinic and the Family Mental Health Unit of St Clare Hospital. Following a 15-year career as a college instructor of biomedical sciences in Wausau, Dr Bell earned a medical degree in 1988 from the Medical College of Wisconsin. He completed a 4-year residency program in Baltimore.

Christine Bockhorn, MD*, is a new staff member at Calumet Medical Center in Chilton. She is board certified in family practice. A 1986 graduate of Wayne State University School of Medicine, Dr Bockhorn served a 3-year residency at the Community Hospital of Indianapolis.

William Campbell, MD*, has been appointed professor and chair of the department of pharmacology and toxicology at the Medical College of Wisconsin. He returns to the college after serving 15 years on the faculty of the University of Texas Southwestern Medical Center at Dallas, where he was a professor of pharmacology. He taught at MCW in 1976.

Richard W. Clasen, MD*, of Nekoosa Clinic in Wisconsin Rapids, has become certified in geriatric medicine after passing the Geriatric Medicine Examination. Dr Clasen serves Riverview Manor, Edgewater Haven, and Family Heritage nursing homes.

Joel Cler, MD*, recently received his board certification from the American Board of Orthopedic Surgery. Dr Cler graduated from the University of Illinois College of Medicine in Peoria. He is on staff at Ripon Memorial Hospital and Berlin Memorial Hospital.

C.W. Crawford, MD*, of Green Bay, is retiring from full-time medical practice.

Dr Crawford began practicing family medicine in Green Bay in 1956, and formed Wellness Associates of Green Bay, Ltd., in 1985. He has been active on the medical staff at St Vincent Hospital, St Mary's Hospital, and Bellin Hospital.

Shahla P. Durrani, MD*, an internist, has joined the staff of Sheboygan Clinic. Dr Durrani earned her medical degree at Dow Medical College in Karachi, Pakistan, in 1983. She then completed an internal medicine residency at Loyola University Medical Center and Hines VA Hospital in Chicago. Most recently, she completed a fellowship in gastroenterology at Baylor College of Medicine in Houston.

John Feilbach, MD, is a new member of the Stoughton Hospital medical staff, serving in the emergency services and urgent care area. Dr Feilbach is a graduate of the University of Wisconsin Medical School. He recently completed an internship in internal medicine at UW and plans to complete a residency in radiology in 1994.

S.I. Fejer, MD*, a board-certified pediatrician, has joined the medical staff at Bay Area Medical Center in Marinette. Dr Fejer comes to Wisconsin from Chicago, where he spent 20 years in private practice. He is affiliated with the Marinette-Menominee Clinic.

Joseph R. Garde, MD*, has joined the staff of the Monroe Clinic and St Clare Hospital. A graduate of the University of Wisconsin Medical School and a native of Monroe, Dr Garde returns to Wisconsin from the Department of Surgery at Maine Medical Center in Portland.

Anthony Gausas, MD, a board-certified specialist in family medicine, recently joined the staff of the Monroe Clinic-New Glarus. Dr Gausas is a fellow of the American Academy of Family Practice. He was in private practice in Michigan prior to coming to New Glarus.

Paul M. Jacobsen, MD*, of Verona, has been elected president of the Wisconsin Society of Anesthesiologists and chair of the SMS Section on Anesthesiology. **W. Stuart Sykes, MD***, of Madison, is the section's newly elected secretary. **Warren J. Holtey, MD***, of Marshfield, has been elected delegate and **Edwin Lee Mathews, MD***, of Whitewater, is the alternate delegate to the SMS House of Delegates.

Debra L. Jaryszak, MD*, has joined Kurten Medical Group in Racine. Dr Jaryszak is a 1988 graduate of the University of Wisconsin Medical School and recently completed a residency in obstetrics and gynecology in Hartford, Conn.

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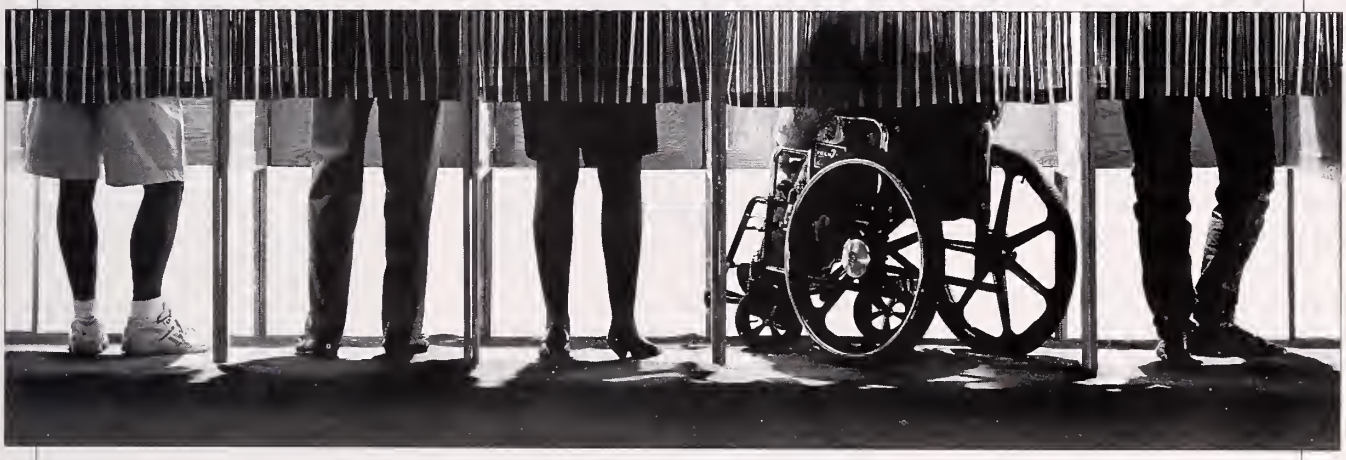

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Susan Kinast-Porter, MD*, a family physician affiliated with the Medical Center of Monroe, has been appointed as a director of the Wisconsin Academy of Family Physicians. Dr Kinast-Porter serves on the SMS Task Force on Domestic Violence and has been a member of the SMS Committee on Safe Transportation since 1985.

Daniel R. Kraeger, DO*, a sports medicine specialist and former assistant athletic trainer with the Chicago White Sox baseball team, has joined the staff of Mercy Hospital Sports Medicine Center in Janesville. Dr Kraeger earned his medical degree from the University of Osteopathic Medicine and Health Sciences at Iowa Lutheran Hospital in Des Moines. He recently completed a fellowship at the Hughston Sports Medicine Center in Columbus, Ga.

Joseph Puccinelli, MD, has joined the Milwaukee Medical Clinic staff and will provide services at the clinic's Cedar Creek Center in Grafton and at the Port Washington Center. Dr Puccinelli earned his medical degree from St Louis University School of Medicine. He completed an internship in surgery and a residency in orthopaedic surgery at St Louis University, where he was chief resident last year.

Cornelius J. Rater, MD*, of Milwaukee, has been named as a fellow of the American College of Radiology. Dr Rater, who earned his medical degree from the University of Iowa College of Medicine, was one of 144 new fellows named by the ACR Board of Chancellors.

Kenneth A. Valyo, DO*, of Dodgeville, has joined Family Practice Associates of Iowa County. Dr Valyo earned his medical degree and served his residency at Chicago College of Osteopathic Medicine in Chicago.

Paul L. Writz, MD*, of Abbotsford, has been selected as Physician of the Year by the Wisconsin Association of Nursing Homes, Inc., for his work at Continental Manor Nursing Home. The award is given in recognition of outstanding attention to the medical needs of the residents in nursing homes beyond the call of duty.

Carol J. Ziel, MD*, is a recent addition to the Eye Clinic of Wausau's medical staff. Dr Ziel earned her medical degree from the University of Kentucky and completed a residency in ophthalmology there. She received the resident teaching award. After her residency, she completed a glaucoma fellowship at Swedish Hospital in Seattle.[150th]

County society news

Columbia-Marquette-Adams. Thomas Boyd, MD, was recently elected a member of the Columbia-Marquette-Adams County Medical Society.

Jefferson. Mary J. Neustifter, DO, was recently elected a member of the Jefferson County Medical Society.

Marathon. John P. Hogan, MD, and Timothy N. Logemann, MD, were accepted to membership at the Marathon County Medical Society annual meeting in October.

Milwaukee. New members of the Medical Society of Milwaukee County are: James C. Bartlett, DO; Mark C. Bates, MD; Christine R. Bryke, MD; James E. Cain, MD; Gordon W. Calderwood, MD; Peter D. Chapman, MD; Burton D. Cox, Jr., DO; Scott W. Donavan, MD; Julie A. Freischlag, MD; Allan L. Goldman, MD; Richard J. Grieshop, MD; Martha F. Jay, MD; Thomas P. Heyerman, MD; Manuel Joseph, MD; Krishna Kumar, MD; Deborah M. Larkey, MD; Deborah L. Manjoney, MD; Thomas R. Marra, MD; Marta C. Muller, MD; Ruben F. Lewin, MD; James T. Moran, MD; Neal Pollack, DO; Kempsagar Ravishankar, MD; Thomas J. Regan, MD; David A. Rein, MD; Andrew J. Seter, MD; Dennis J. Tishko, MD; Timothy Vellinga, MD; Bruce C. Wilson, MD; Donald J. Wilson, MD; Susan Lee Ahart, MD; Everton L. Arrindell, MD; William J. Boehm, MD; Claudia C. Capurro, MD; Thomas K. Carlson, MD; John R. Cochran, MD; Thomas A. Deering, MD; Patrick A. Dowling, MD; Todd M. Doenier, MD; Michael M. Farooq, MD; Adine Feuer, MD; Jeffrey T. Follansbee, MD; Frank S. Fortenberry, MD; Michael R. Gallagher, MD; James B. Gosset, MD; Zahida P. Haq, MD; Karen Marie Hegmann, MD; Mark A. Hlava, MD; Miqdad A. Khan, MD; Molly D. Kramer, MD; Christine E. Langemo, MD; Rosario B. LaRose, MD; KeriLynn Loftus, MD; Daniel Lopez, MD; Brian E. Lundeen, MD; Keith L. Mausner, MD; Marianne Mikat-Stevens, MD; Michael L. Murphy, MD; Gregory J. Nelson, MD; Rebekha G. Neu, MD; Kevin S. Packman, MD; Farshid Paydar-Ravandi, MD; Mark H. Rossing, MD; Bart J. Schmidt, MD; Bruce A. Semon, MD; Kerry M. Simon, MD; Stephen M. Sokolyk, MD; Michael K. Taylor, MD; Abraham Varghese, MD; Matthew A. Vierkant, MD; Mitchell D. Wolf, MD; Shahrzad Zarghamee, MD; and candidates Sandra Kitson and Mary K. Portz.

Oneida-Vilas. Twenty-five members were present at the September meeting of the Oneida-Vilas County Medical Society to hear Mike Kirby, director of government affairs for the State Medical Society, speak on political topics of health care and discuss the health care proposals of the two presidential candidates. He also addressed other legislative problems of medical interest. Also present was Julie Dagget, the new field representative for

the district, who gave a brief presentation on domestic violence. Linda R. Powers, MD; Laura Hammel, MD; Russell Hermus, MD; Jodelle Bentley, MD; and Peter J. Santogade, MD, were accepted to membership in the society.

Racine. Paulette Y. Coty, MD, was elected to membership at the September meeting of the Racine County Medical Society.

Rock. Dr Murdy summarized an SMS legal presentation detailing antitrust facts for physicians. New members accepted into the society were: Mark D. Lupton, MD; Michael K. Abernathy, MD; F. Ward Blair, MD; Larry V. Carson, MD; Gary L. Cohen, MD; Leonard P. La Civita, MD; Cynthia M. Bender, MD; Kimball S. Fuiks, MD; Douglas R. Molin, MD; Jeffrey A. Stephenson, MD; Francis Kaveggia, MD; Sushrut R. Patel, MD; Julie P. Wilson, MD; James H. Arant, MD; Mark D. Canty, MD; James J. Tydrich, MD; Munira Patel, MD; Richard D. Larson, MD; and Susan J. Olson, MD.

Rusk. Thirteen members were present at the September meeting of the Rusk County Medical Society to hear Dr. Priscilla Hollander, International Diabetes Center in Minneapolis, speak on "New Ideas for the Treatment of Type II Diabetes".

Waukesha. The following physicians have been accepted to membership in the Waukesha County Medical Society: Jain Asha, MD; Philip Bain, MD; J. Bargenquast, MD; Daniel Cheng, MD; Maja Jurisic, MD; Kevin Kass, MD; Gary Kohlenberg, MD; Susan Kroener, DO; John Milbrath, MD; Tim Morton, MD; David Nienhuis, MD; Paul O'Neill, MD; Richard Schaefer, MD; Robert Schmus, MD; Madelyn Sieraski, MD; Jennifer Vipond, MD; William Wacker, MD; MaryJo Wakeman, MD; and David Yenerich, MD.

Oshkosh. Forty-nine members were present at the September meeting of the Winnebago County Medical Society meeting to hear Carl Junkerman, MD, speak about professional ethics. Sangita Patel, MD, was accepted into membership.[150th]

Obituaries

Louis Babby, MD, 84, of Milwaukee, died July 17, 1992. Born Dec 11, 1907 in Milwaukee, Dr Babby was a graduate of Marquette Medical School. He served on the staff of Deaconess Hospital, St Lukes Hospital and the Good Samaritan Medical Center. His wife, Esther, preceded him in death. He is survived by a son, Phillip, and five grandchildren.

Joseph F. Boyle, MD, 67, former executive vice president of the American Society of Internal Medicine and president of the American Medical Association, died July 16, 1992, in Williamsburg, Va. Dr Boyle received his medical degree from Temple University. For 30 years, he practiced internal medicine, specializing in diseases of the chest, in Los Angeles. From 1975 to 1983, he served as a member of the AMA Board of Trustees, and from 1984 to 1985 as AMA president. In 1985 he became ASIM's chief executive officer, retiring March 25, 1992.

Anthony T. Buscaglia, MD, 78, a former Milwaukee physicians, died May 19, 1992, in California. He was born April 28, 1914, in Buffalo, NY. Dr Buscaglia was a physician and surgeon in Milwaukee for 40 years before retiring from practice 10 years ago. Surviving are his wife, Paulina, of Hilton Head, SC; one daughter, Carol Wertz, of New Berlin; two sons, Richard, of Wauwatosa, and Christian, of Palm Desert, Calif.

Ted S. Buszkiewicz, MD, age 73, of Greenfield, died July 8, 1992, in Milwaukee. A 1944 graduate of the Marquette School of Medicine, Dr Buszkiewicz served his residency at Milwaukee Childrens Hospital. He served in the US Army medical corps during WW II from 1945 to 1947 and was again called to active duty in 1953. Dr Buszkiewicz, a member of the SMS and the AMA, opened his private practice in Milwaukee in 1950, and retired in 1987. Surviving are his wife, Evelyn; daughters Lynn Raoofi, of Phoenix, and Joel Garny, of Milwaukee; and five sons, Mark, of Deaux, Miss, Ted, of Milwaukee, Chris, of Tampa, Jim of Albuquerque, and Bill, of New York City.

Continued on next page

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.[150th]

Continued from preceding page

Willaim L. Cochrane, MD, 76, of Rogersville, Tenn, and a former Three Lakes physician, died July 4, 1992, in Tennessee. A graduate of the University of Illinois Medical School, Dr Cochrane was a physician in Three Lakes during the 1960s and 1970s. He also practiced in Wayside and Beloit. Survivors include three sons, William B. and Richard, both of Hiles, and David, of Rogersville; 12 grandchildren and one great granddaughter.

Edna M. Cree, MD, 84, of Middleton, died June 26, 1992, in Madison. She was born Aug 14, 1907, in East Colebrook, NH. Already an RN with a master's degree in public health from the Massachusetts Institute of Technology, she served as an epidemiologist in Europe during World War II, where she met Dr William Middleton, who recruited her as a student. Dr Cree graduated from the University of Wisconsin Medical College in 1951, and interned at Strong Memorial Hospital in Rochester, NY, before returning to UW for an internal medicine residency. She completed a research fellowship in cardiopulmonary physiology at Bellevue Hospital. In 1958, she returned to Madison to work for the Veterans Administration Hospital, retiring in 1976. Dr Cree was chief of the pulmonary emphysema unit and associate professor of medicine for UW. She is survived by a sister; three nieces; and three nephews.

Robert A. Frisch, MD, 88, died June 27, 1992, in Milwaukee. Dr Frisch practiced medicine in Milwaukee for nearly 60 years. A 1925 graduate of Yale Medical School, Dr returned to Milwaukee in 1933 and joined the staff of what is now Sinai Samaritan Medical Center. He also worked at Columbia Hospital and the Milwaukee veterans hospital. A cardiologist and SMS member, Dr Frisch served as president of the Milwaukee County Medical Society, president of the Wisconsin Heart Association, president of the Milwaukee Academy of Medicine and was a member of England's Royal Academy of Medicine. He was a former chief of staff at Mount Sinai Hospital. He is survived by his sons, Robert, of Milwaukee, and Stephen, of Shorewood; a daughter, Hannah, of Chicago; and a brother. His wife, Elizabeth, died in 1971.

Arthur Andrews Holbrook, MD, 86, of Mequon, died July 8, 1992. Dr Holbrook earned his medical degree from Harvard in 1932 and served an internship at Massachusetts General Hospital. An internist and member of the SMS, Dr Holbrook practiced medicine in Milwaukee from 1935 until his retirement in December 1975. He is survived by his wife, May; a daughter, Elizabeth Chesnut; a son, Morris B. Holbrook; one brother; and four grandchildren.

David M. Kashnig, MD, 46, a neurologist and former chief of medical staff at St Michael Hospital in Milwaukee, died July 19, 1992, at his home in River Hills. He graduated from the University of Wisconsin Medical School. A member of the SMS, Dr Kashnig's research earned him the Stoval Award from the Wisconsin chapter of the American Cancer Society. Surviving are his wife, Heather Buxton, of River Hills; his parents, Arlene and Robert Kashnig, of Sheboygan; and a sister.

Eugene M. Kay, MD, 92, died June 10, 1992. A native of Germany, Dr Kay earned his medical degree in Munich in 1924. He interned in Munich and Berlin before serving residencies in Berlin and Hamburg. A general practitioner and SMS member, Dr Kay began practicing medicine in Milwaukee in 1934 and continued until his retirement in 1970 when he moved to Palm Desert and Santa Monica, Calif. Survivors include his wife, Margaret; a son Eugene, of Denver; and daughters, Barbara Polland, of Los Angeles, and Lynn Greenberg, of Santa Monica; seven grandchildren and two great grandchildren.

Norval W. McKittrick, MD, 85, died July 15, 1992, in Bayside, where he had resided for 27 years. An internist and member of the SMS, Dr McKittrick graduated from the University of Nebraska Medical School in 1932. He is survived by his wife, Betty; a son, Gary, of Mequon; a daughter Mary Ackerman, of Fullerton, Calif; four grandchildren and five stepchildren, Bonnie Andrews and Donald Thiel, both of Mequon, James Thiel of Random Lake, Paul Toepfer, of Cedarburg, and Dr John Toepfer, of Toten, SD.

Sheryl Ann Spitzer, MD, 34, died June 1, 1992, in Madison. Dr Spitzer was born in Ashley, ND, Oct 4, 1957, and graduated from Washington University School of Medicine in 1985. She completed her residency in internal medicine at the Gundersen Clinic-Lutheran Hospital in La Crosse. She was associated with the Midelfort Clinic in Eau Claire, and in 1991 she became a member at the Dean Medical Center in Madison. She was a member of Eau Claire-Dunn-Pepin County Medical Society, the SMS, and the AMA. Surviving are her parents Carrold and Marlene Spitzer, of Ashley, ND.

Edward W. Vetter, MD, 83, of Fond du Lac, died June 9, 1992, at his home. Dr Vetter was born Feb 17, 1909, in Stevens Point. He was a veteran of WW II, serving in the US Army Medical Corps from 1941 to 1946. He received his medical degree from Marquette School of Medicine. Dr Vetter practiced medicine in Randolph from 1938 to 1941, then served in WW II from 1941 to 1945. He then went to New York Medical College for post-graduate surgery and served his surgical residency in Canton, Ohio, after which he joined the Fond du Lac Clinic in 1948. He was on staff at St Agnes Hospital as a surgeon until his retirement in 1977. He was a member of the AMA, the SMS and Fond du Lac County Medical Society. Surviving is his wife, Myrtle; one sister; and seven nieces and nephews.

Celso A. Villavicencio, MD, 66, of Portage, died June 3, 1992, in Madison. Dr Villavicencio was born April 12, 1926, in Manila, Philippines, and earned his medical degree at Manila Central University. He became a US citizen in 1963. Dr Villavicencio completed residencies in surgery, orthopedics, and obstetrics-gynecology. He practiced in Portage for 29 years. He was a fellow in the AAFP and the chief of staff at Divine Savior Hospital in

Portage in 1990-1991. Surviving are: his wife, Mary; sons, David, of St Paul, Mark, of Portage, and Philip, of Evanston, and daughter, Lisa, of Milwaukee; five brothers and sisters; and seven grandchildren.

Andrew Paul Vrabec, MD, 70, formerly of Beaver Dam, died July 8, 1992, in Sun City-West, Ariz. Dr Vrabec was born Nov 18, 1921, in Milwaukee and graduated from the University of Wisconsin Medical School. He served the Beaver Dam community for 36 years as a family physician and surgeon. He retired to Arizona in 1988. He is survived by his wife, Cecilia; four daughters Patricia Staats, MD, Barbara Sheperd, of Madison, Nancy Vrabec, of Milwaukee, and Mary Rausch, MD, of Glendale, Ariz; two sons Peter Vrabec, of Baraboo, and Michael Vrabec, MD, of Burlington, Vt; and eight grandchildren. A scholarship fund in Dr Vrabec's memory is being established at Beaver Dam High School.

Edward J. Zeiss, MD, 91, died July 16, 1992 in Appleton. Born Mary 15, 1901, in Chicago, Dr Zeiss was one of Appleton's first board-certified ophthalmologists. Dr Zeiss graduated from Northwestern University Medical School in 1932 and practiced as a family physician in North Dakota until 1937 when he began a residency in ophthalmology at Chicago's Cook County Hospital. He moved to Appleton in 1939 and went into solo practice there in 1959. He was later joined in practice by his son and Ross Mueller, MD. He retired in 1976. Dr Zeiss was active in the AMA and the SMS and served as president of the Outagamie County Medical Society and the Wisconsin-Upper Michigan Society of Ophthalmology. Surviving are his wife, Alice; son, John, both of Appleton; daughter Susan Zeiss Wollwage, of Payallup, Wash; and six grandchildren.

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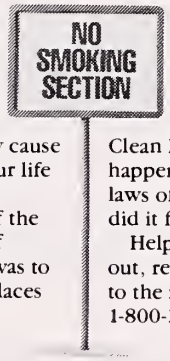

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AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

April 1992
* Biehl, Mark D., Waukesha
* Bruckman, James E., Milwaukee
* Chilinski, Steven G., Janesville
* Coleman, Edward J., Green Bay
* Cooper, Ronald J., Waukesha
* Gagrat, Dinshah D., Wauwatosa
Gladieux, John R., S. Milwaukee
* Grotenhuis, Paul W., Rhinelander
* Knuteson, Edward L. R., Monroe
* Laing, Robt. E., Racine
* Longstreth, Chas. R., Ashland
* Peterson, Robt. L., Waupaca
* Rammer, Martin A., Sheboygan
* Rankin, James J., Brookfield
* Rizzo, Michael J., Kenosha
Roh, Byung L., New Berlin
* Swanson, Brian C., Superior
Taclob-Tiu, Lou Divina F., West Allis
* Ullrich, Peter H., Eau Claire
Workman, Barbara E., Redgranite
* Zirneskie, Jos. D., Middleton

May 1992
* Annesley, Wm. H., Wauwatosa
* Ayengar, Shanta, Milwaukee
* Balder, Roy B., Elroy
* Beaumont, Robt. J., Waukesha
* Bollom, Steven J., Green Bay
* Bradley, Walter J., Franklin
* Burg, Edward A., Milwaukee
* Caine, Marc R., Milwaukee
* Crapster-Pregont, Barbara, Merrill
* Dralle, Wm. G., Milwaukee
* Drury, Colin J., New Richmond
* Duenk, Larry L., Oostburg
* Gould, Mary J., Madison
* Grajewski, Michael A., Watertown
* Gremmels, Frederick C., Watertown
* Hartwick, John P., Wauwatosa
* Holden, Richard C., Watertown
* Hughes, Jack L., Wauwatosa
* Keenan, Owen B., Marshfield
* Kleinberg, David C., Milwaukee
* Maurer, Wm. J., Marshfield
* McMillen, Milton R., La Crosse
* Mehr, Michael P., Marshfield
* Norfleet, Robt. G., Marshfield
* Patterson, Katherine P., Minocqua
Santiago, Jos. A., Milwaukee
Sorenson, Chas. C., Nekoosa
* Tiu, Alfonso L., West Allis
* Ulmer, Richard H., Marshfield
* Van Liere, John D., Burlington

June 1992
Agoncillo, Jose R., West Allis
* Avecilla, Constante S., Marshfield
* Bianco, Jos. A., West Salem
* Bolger, John T., Waukesha
* Carothers, Karmel L., Milwaukee
* Clouse, Lawrence, H., Marshfield
* Cochrane, Bruce J., Watertown
* Hackney, Robt. H., Ladysmith
* Hansotia, Phiroze L., Marshfield
Harris, Frank S., Marshfield
* Herbert, Timothy G., Marshfield
* Janssen, Martin L., Friendship
* Johnson, Sidney E., Marshfield
* Kennedy, Jane E., Marshfield
* Kuehner, Marvin E., Marshfield
* Luckey, Wm. T., River Hills
* Matheus, Andrew T., Ashland
* Mc Donough, John W., Wisconsin Rapids
* Mc Mahon, Richard F., Elm Grove
* Medchill, Michael T., Chippewa Falls
* Miller, Wm. C., Wausau
* Optiz, James C., Marshfield
Otters, Anthony A., Marshfield
* Ozkazanc, Ismet B., Marshfield
* Park, Roger W., Marshfield
* Paulson, John K., Stevens Point
* Sharon, Mark A., Plymouth
* Siepmann, James P., Oshkosh
* Sipes, Don R., Green Bay
* Smith, Martin J., La Crosse
* Turney, Susan K., Marshfield
* Weinlander, Chris M., Appleton

July 1992
* Braun, Andrew J., Stevens Point
* Jenk, Lloyd F., Milwaukee
* Lewis, James M., Baraboo
* Marlett, Myron M., Green Bay
* Miller, John J., Milwaukee
* Preisler, Gary L., West Bend
* Roden, Wayne, Kenosha
* Twiggs, John T., Marshfield

August 1992
* Arndt, George W., Neenah
* Bartholmai, Jack R., Beaver Dam
* Charipar, Ron M., Ladysmith
* Cleveland, David A., Marshfield
* Damiani, Kathleen K., Greendale
Fishman, Paul A., Mequon
Fritsch, Michael K., Sun Prairie
* Greenfield, Andrew K., Appleton
* Greenlaw, Robt. H., Marshfield
* Jachowicz, Robt. B., Hales Corners
Kutom, Ali, Waukesha
* Larson, Carol Ann, Marshfield
* Liss, Paul L., Marshfield
* Malinowski, Rodney W., Racine
* Miech, Donald J., Marshfield
* Smale, Jeffery R., Milwaukee
* Smith, Peter N., Marshfield
* Snow, Patrick D., Appleton
* Stanley, Robt. J., Madison
* Thomalla, James V., Marshfield
* Thorngate, Stephen, Park Falls
* Turke, Terry L., Watertown
* Vincent, Robt. Allen, Oshkosh
Welker, Dorothy H., Minong
* Zajac, Dorothy J., Janesville[150th]

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Family Practice Physician Board Certified - Board eligible to join 25 physician multispecialty group in Winona, Minnesota with existing four physician Family Practice Department. Total draw of 40,000 population. Competitive salary offered. Interested physicians please contact: J. B. Knuesel, Administrator, Winona Clinic, Ltd., 420 East Sarnia, Winona, MN 55987. 10-12/92

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Family practice. Physicians seeking a BE/BC family practice physician for the Norway, Michigan, service area. The physician would have the option of joining one of the existing practices and/or setup his/her own practice. Anderson Memorial Hospital is a part of Dickinson County Hospitals and has a service area population of over 45,000. Contact: Dr. Paul Hayes' office (906) 563-9255 or Dr. William Gladstone's home (906) 563-8743. Anderson Memorial spital, Main Street, Norway, Michigan 49870, (906) 563-9243. 10/92

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Physicians Exchange

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The Wausau Medical Center is seeking board certified/eligible individuals in the following specialties: dermatology, family medicine, gastroenterology, hematology/oncology, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed

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Physicians Exchange

Continued

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Contents

November 1992 Vol. 91 No. 11

Opinions

617 *President's page*
Safe at home (?)
by William J. Listwan, MD, West Bend

620 *EVP report: The view from here*
The sun also rises
by Thomas L. Adams, CAE, Madison

622 *Letters*
This shouldn't happen here
by V. Cameron, MD, Athens

624 Interfering in the patient-physician relationship
by Jerome C. Andres, MD, Mosinee

624 Name game
by Louis Charles Hacker, MD, Marshfield

Scientific

627 Magnetic resonance appearance of a rare intradural chordoma
by Robert C. Hardie, MD, Milwaukee

629 Unilateral seminal vesicle cyst presenting as hematospermia; diagnosis established by transrectal prostatic ultrasound
by J. S. Mayersak, MD, and Carl J. Viviano, MD, Wausau

Socioeconomic

633 *Public health*
The increasing health and economic burden from cigarette smoking in Wisconsin
by Nancy Chudy, MPH; Patrick L. Remington, MD; and Richard Yoast, PhD, Madison

636 Medical Assistance to offer prenatal care coordination as benefit

Organizational

637 A Wisconsin medical team travels to the Dominican Republic
by Peter J. McCanna, MD; Patrick J. Saine, MEd, CRA; Paul Mullaney, MD; Pamela Avery, MD; Carol Czomak, RN; and Margaret Helin, RN, Madison

642 Providing health care for the Hmong
by David A. Waters, MD; Rama B. Rao, MD; and Helen E. Petracchi, PhD, Milwaukee

652 Three SMS members elected to WIPRO Board

653 The march of medicine: H. Kent Tenney, MD
by LeeAnn Kahlor, SMS student intern

654 A glimpse into our past

655 Physician briefs

657 County society news

658 Obituaries

Our cover: Wisconsin reaches out to the Dominican Republic. See related story on p. 637.

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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Created by the Territorial Legislature in 1841 and now representing nearly 7,500 member physicians, the Society's purpose is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society concern medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, service to physicians, operation of the Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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President's page

Safe at home (?)

William J. Listwan, MD

IT'S BEEN A LONG and tiring day, the sun has set, and we are settled in at home to relax and enjoy our family. We button up the front and back doors to the house and lock them, and proceed to go around the house either pulling shades, drawing curtains, or closing the blinds. Inside of our home we are safe and secure. Safe from most of the troubles of the world and certainly from the violence that can be found on the streets of our cities. There is no place like home!

Actually, millions of Americans may be at more risk of physical harm and abuse in their homes than on the streets. The medical literature clearly tells us that the leading cause of emergency room visits for women between the ages of 15 and 44, and the second leading cause of emergency room visits for women of all ages, is domestic violence. Many more battered women are being seen in our offices on a routine basis, not necessarily with physical signs of battering.

The more I learn about the issue of domestic violence, and the more I become involved with people that have been working on this issue for years, the stronger I feel about the need for our profession to get involved. As I travel Wisconsin meeting with physicians at county medical societies, clinics, and hospitals, I have given my presentation about domestic violence. I hope that it is not only thought provoking, but that it eventually leads to some action. Physicians need to know that they are not expected to be the solution to the problem. Physicians, however, have significant contact with the victims of domestic abuse: women, children, and the elderly. If we are not aware of the possibility, and if we do not confront it openly and honestly, many opportunities to help these people live a safe and happy life will be lost. It really is important for us to get involved–every one of us.

There seem to be a number of myths that surround domestic violence, particularly in the minds of physicians. I would like to address these with you today.

Myth 1

Domestic violence occurs only in certain populations.

The occurrence of domestic violence is totally unpredictable. Neither the batterer nor the victim can be predicted by education, appearance, socioeconomic status, or age. Although children who are battered may grow up to be batterers or victims, this is not a good predictor of abuse. Domestic violence occurs in the families of physicians and other professionals where it is frequently overlooked or ignored.

Myth 2

The victim must enjoy being battered or she would leave.

There are multiple reasons for victims staying in a battering relationship. They may be motivated by fears about their own safety or the safety of the children. Economic factors need to be considered. And, frequently, the victims feel isolated, responsible, and confused about the violence that is going on. Since the batterer is often kind and charming 95 percent of the time, the victims usually have the false hope that somehow the battering or violence will stop.

Myth 3

These social problems just can't be solved.

Certainly, these are complicated situations and do not have an easy solution, but there is no reason to throw up your hands in dismay and walk away from the problem any more than you would walk away from a complicated medical problem. It is not our job to singlehandedly identify and solve these problems; indeed, our nurses and other support personnel may be in a better position to identify some of

Continued on next page

Continued from preceding page
these problems than we are. When the problem is identified, our job is to let the victim know that they are not alone and that pain and fear are not part of a normal relationship. They should be told that they are not at fault, that help is available from others who have been in a similar situation, and that we are concerned about their safety. At that point, it would be appropriate to give them the name and phone number of a local shelter and urge them to make contact with that group to receive further information. It would probably be wise to offer to let them use the phone in your examining room right at that moment, as they may be afraid to make this call from home.

Myth 4

These issues are time consuming and not appropriate for a physician's office.

Routine screening questions about relationships should be asked with every yearly physical and health maintenance examination and are not time consuming. In the case of a patient who does share her problem with you, and does need affirmation, empowerment, and referral, it may take a little extra time. But the time spent is worthwhile. You may have done more for that patient's physical complaints and problems than you will ever realize. It is my belief that a good amount of chronic fatigue, chronic and recurrent pain problems, and what appear to be inappropriate use of the emergency room and office, may be related to attempts on the part of the patient to get into a safe environment or a subconscious wish that somebody would finally ask them if they are living in pain or fear.

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Myth 5

These situations are always frustrating.

True, the patient may not be willing to make contact with a shelter or support group immediately. They may not seem to be following your recommendation that they get help, but if you do care about them and do offer support, they may respond at a later time, a time of their choosing, a time when they are ready to consider changing or leaving their relationship. You must let them know that there are others who have been through similar situations who are willing to discuss the options with them and make the information about the name of the organization and phone number available to the patient. It must be the patient's choice.

Myth 6

Alcohol and Drugs are usually the cause of domestic violence.

Although some abusers and some victims also have a problem with alcohol and drugs, these must be treated as separate issues. Certainly, for the patient who has an alcohol or drug problem, that must be treated at the same time the domestic violence issue is addressed. Alcohol may aggravate a domestic violence situation, but does not cause it. People who try to control others through physical violence or intimidation do not learn this behavior from alcohol.

Myth 7

My patients will be offended if I ask questions about their relationships or possible domestic violence.

I have found that any embarrassment in asking the question is on my part, not on the part of my patients. Those patients who are not involved in violent relationships actually seem to feel good that I care enough to ask about the status of their relationship. It is another way of showing that I do care about them in a very important part of their life. At this point, if one of my patients became angry or upset with me for asking, I would strongly suspect that they were involved in a violent relationship. I wouldn't push the issue, but I wouldn't worry about having offended them either.

It is my hope that during this year there will be a marked increase in cooperation among the various groups and organizations that deal with children, adults, and the frail elderly who are involved in violent relationships. In this area, we will not necessarily be the team leaders. We are, however, an important part of the team. We are important because we frequently have interactions with the victims involved in these situations on a regular basis. We also enjoy their confidence and our concern and recommendations will have a definite impact on them.

It's also valuable to know that special programs have been set up in various parts of the state for the batterers. These programs have met with mixed success. The problems are deep and not necessarily easy to solve. I think it is important to recognize that referral of the batterer for counselling or psychological evaluation alone is not adequate. They must be placed in contact with a program that specifically deals with the issues of domestic violence.

You can make a difference in the lives of those around you, both the victims and the perpetrators of violence. Help them to "break the chain of pain" that binds them.[15pt]

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EVP report: The view from here

The sun also rises

My maternal grandmother, Luna Clementine Coble, was born on a large farm in rural North Carolina in 1898. There was no electricity, running water or telephone. Cooking for the family of eight was accomplished by her mother and sisters in a semi-detached kitchen over a wood stove.

Grandmother's birth occurred a little over 100 years after the scrapping of the Federal Articles of Confederation and adoption of the Constitution, which gave us the framework for the strong central government that we have today. In terms of hardship, life had really changed very little in that 100 years.

As a young boy, I remember sitting in her lap in a rocking chair on her and grandfather's wide front porch while she told stories of her youth in those simpler times. Nights of tending fires by tobacco sheds to help "cure" the tobacco, being driven by horsedrawn carriage to school and stories of losing siblings and cousins to things like typhoid and tetanus.

In the 73 years that she would live, she reared a family, saw the panic of 1898, learned to drive a car, talked on a phone, flew in an airplane, survived the Great Depression, went to the movies, heard radio and saw a television. She also witnessed the conquering by medicine of typhoid, malaria, polio, and many other diseases that killed the young of her generation.

Continued on page 622

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Continued from page 620

As we approach Thanksgiving, I am struck by many of the similarities between the late 20th century and the late 19th century. Both eras were times of enormous change–economically, politically and culturally. For instance, the October 1987 Black Monday roughly parallels the Panic of 1989. And while the election of 1892 saw the last of the Civil War era candidates "waving the bloody shirt," the election of 1992 seems to have signaled at least the beginning of the end for the World War II era candidates.

The enormous advances that my grandmother saw as one century closed and another opened may very well be echoed as we move into the 21st century. Today, we look back on the leaches used by physicians 100 years ago and–armed with our vaccines, antibiotics, MRIs and laser surgeries–we shake our heads in happy disbelief at how far we've come. I can't help but wonder which of our modern medical miracles will be considered quaint, if not downright primitive, by our children and grandchildren.

With this Thanksgiving, however, I am as thankful for the promise of the future as I am for the bounty of the present. As we peek over the horizon of tomorrow we glimpse only hints of what is to come, but even those glimpses are breathtaking: space stations, magnetic levitation trains, ecologically sound industries, vaccines against cancer and virtual reality entertainment, to name only a few. No part of our lives will go untouched by our reinvigorated exploration, expanding knowledge and advancing technology.

There is, of course, no guarantee. Advances have been thwarted before by those entrenched in the status quo or fearful of the future. Past advances have also been misapplied. Frequently, our wisdom has not kept pace with our knowledge. In the days to come, great debates will rage. There will be times of confusion and anxiety. There will be days when we seem to stand at the edge of chaos and despair. Change is never easy.

There is a grammar school story about George Washington sitting, at the signing of the Declaration of Independence, in a chair that had a half sun engraved into the top of its back. As Ben Franklin watched the historic event unfold, he wondered whether the sun over Washington's head was rising or setting. For Franklin, it became a symbol of the new nation and his fears for its future.

It was rising then, of course, but is it still? Has the American sun reached its zenith? Is it now slowly setting?

Call me an optimist if you will, but I believe we will get beyond our next phase of growth, stronger for having survived the struggle. We know (although we sometimes forget) that while democracy is one of the messier forms of government, from that apparent disarray rises our strength–over and over again. If it is naive to believe that we will rise again, I will happily plead guilty to the charge.

The American spirit perfumes the air, like magnolia blossoms in the spring. Americans still refuse to believe that there is any goal beyond their abilities. Americans are still driven, after more than 200 years, by the fires sparked when the passions of rugged individualism and genuine compassion reside within a single heart. The sun also rises today. And that is something for which to give thanks.

Opinion policy

Opinions expressed in the Voice of the SMS section reflect the official policy of the State Medical Society of Wisconsin.

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Letters are signed by the authors. These opinions are the authors' and do not necessarily reflect the policies of the SMS. Authorship of letters is open to the public, but letters are limited to 500 words and subject to review by the *WMJ* editorial board. Write to: *Wisconsin Medical Journal*, PO Box 1109, Madison, WI 53701.

Letters

This shouldn't happen here

To the editor: Recently, I had written a letter to the *WMJ* about us physicians concentrating on high-tech lucrative medicine and relegating aspects of real medicine to paraprofessionals and others. Ironically, just at this moment today as I write this letter, a very sad case came to my clinic which scores the point. I would wish the story will nudge the conscience of my physician peers to look seriously at this issue.

A 73-year-old woman walked into my clinic from nowhere, complaining of kidney pain, back pain, and chest pain.

Continued on page 624

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Continued from page 622
She never had a regular physician all her life (for a variety of reasons). Her regular physician, according to her, is a chiropractor who was doing her blood tests, EKGs, and treating her for the last 6 months for urinary tract infections with medications, etc. My nurse took the history and got her permission to have her records obtained from her previous physician (chiropractor). As I entered the room, I noticed that the floor under her chair was soaked with blood and she was all bloody from a bleeding fungating breast tumor. She said she had the pains in the back and chest for 6 months, but that her other physician could not help her. At the present juncture, I am shocked but I'm proceeding with x-rays and other evaluations.

This lady lives in an area which has no shortage of physicians. In fact, she is only 20 miles from my clinic and 20 miles from a large multi-physician clinic of 400 physicians, and only 10 miles from a clinic with five physicians. I am a little cynical about our country when I see the quality of leadership in our politicians but I know that our profession and physicians are capable of better than this. This sort of thing should not happen in America, especially in Wisconsin.

–V. Cameron, MD
Athens[150th]

Interfering in the patient-physician relationship

To the editor: Upon reading the announcement of the enactment of Wisconsin Act 250, I was surprised that the interference in the patient-physician relationship has come to this point. To make it a crime for me to adjust billings on the services which I provide as I see appropriate is simply incredible.

I have found that this bill originated in a committee recommendation with the backing of the insurance industry. I suspect that the insurance companies who already enjoy privileged tax status as well as the power to terminate or exclude benefits for their policy holders on a discretionary basis feel that they're not getting their fair share of those few dollars that the physician is willing to forgive. They seem to have forgotten their purpose was originally to distribute the cost of health care over large populations of people as to assure that catastrophic occurrences by the individual would be minimized. In pursuit of higher profit, I am surprised that they would choose to focus on this issue.

In addition, if the purpose of this law is to assure that a deterrent to overuse or abuse of the medical systems does not occur, I would argue it is unnecessary. Most physicians understand the appropriate use of the medical system, and I doubt that any would encourage abuse of the system by waiving fees under inappropriate situations.

All this law accomplishes is the escalation of the cost of medicine to our society at the expense of destroying a practice graciously extended by the provider and usually genuinely appreciated by the recipient. Therefore, in the true interest of being an advocate for the patient as well as the need for physicians to begin to take back control of our profession, I submit that we must challenge this law and work to the best of our abilities and resources to reverse this atrocity.

–Jerome C. Andres, MD
Mosinee[150th]

Name game

To the editor: William Houghton, MD, had an "Soundings" article in the August 1992 issue of *Wisconsin Medical Journal* on pages 274-276. Dr Houghton stated in his article that he sincerely apologized that there was something here to offend every faction. I am not sure that he was aware that his title "Hackers: A Play in Six Scenes" might also be offensive to someone.

–Louis Charles Hacker, MD
Marshfield[150th]

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- Limited to 10 pages, typewritten, double-spaced, 1-inch margins
- Illustrations are encouraged, but must be included in the 10-page length limit
- The Editorial Board of the *Wisconsin Medical Journal* serves as the panel of judges and has final authority in all decisions

Criteria:

- *Scientific merit:* research methods, data analysis, subject or patient population selection, control of variables, literature analysis
- *Applicability:* usefulness of results to private practitioner, academician, researcher
- *Content:* depth of analysis, continuity of discussion supporting the main thesis, feasibility of conclusions
- *Innovation:* uniqueness of idea, creativity, improvement of existing techniques, previously undiscovered data, advancement of basic understanding
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Deadline: Entries must be received by the *Wisconsin Medical Journal* no later than February 19, 1993: PO Box 1109, Madison, WI 53701

Magnetic resonance appearance of a rare intradural chordoma

Robert C. Hardie, M.D., Milwaukee

Chordomas are rare neoplasms that arise from remnants of the primitive notochord and typically occur in the sacrococcygeal and sphenooccipital regions and less commonly in the vertebral column. We report the magnetic resonance findings of a rare intradural prepontine chordoma.

Case report

A 28-year-old woman with a previous temporal lobe craniotomy for excision of an intradural chordoma of the interpeduncular and prepontine cisterns presented one year later with increasing headaches, hearing loss in her right ear, and acute onset of diplopia. A cranial CT scan showed a questionable area of increased attenuation in the pons without evidence of bony destruction. An MRI scan demonstrated on both the axial (TR/SE 2000, TE 20) and sagittal (TR/SE 500, TE 25) images a mixed signal mass anterior to the pons and medulla (Fig. 1, 2). The mass extended to the right of the midline into the cerebellopontine angle cistern, displacing the pons and medulla posterior and to the left. At craniotomy, a pathologically proven intradural chordoma was excised. Microscopically, the tumor cells ranged in shape from ovoid to elongate with an eosinophilic cytoplasm, which in some areas appeared vacuolated. Immunoperoxidase stains for S-100 were strongly positive. Keratin and pre-keratin stains were positive. The tumor was not felt to be malignant because it was not locally invasive or demonstrated bony destruction. Postoperatively, only the right hearing loss remained.

Reprint requests to: Robert C. Hardie, MD, department of radiology St Luke's Medical Center, PO Box 2901, Milwaukee, WI 53201-2901. Copyright 1992 by the State Medical Society of Wisconsin.

Discussion

The notochord is the embryonic precursor of the vertebral column appearing in the 4th week of embryonic life and regressing by the 7th week with replacement of elements that form the future vertebral column. Chordomas are believed to arise from remnants of the notochord that are distributed throughout the neural axis. Fifty percent of chordomas occur in the sacrococcygeal region, 35% in the spheno-occipital area, and 15% in the vertebral column with a majority at the cervical level.

Ectopic notochord tissue has been reported to be found in an intradural location anterior to the pons in 2% of all autopsies. This has been termed "enchondrosis physaliphora" and has been suggested as the precursor to intradural prepontine chordomas.[1] Mapstone et al[1] described a 26-year-old who presented with bilateral sixth nerve palsies and left-sided weakness and was found to have an intradural prepontine chordoma. Sze et al[2] described a clival chordoma which was totally intradural. Another report[3] described a case of an intradural prepontine chordoma found incidentally at autopsy.

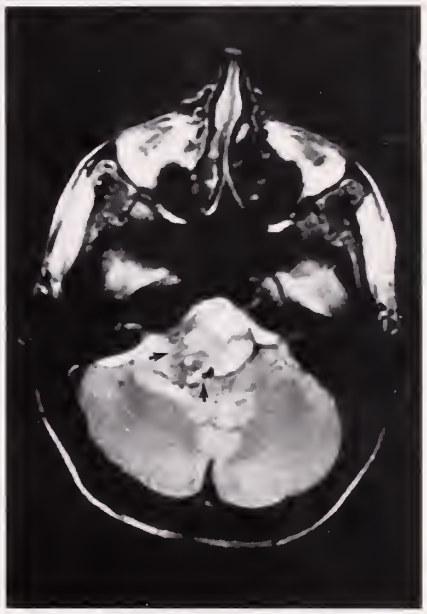

Fig 1.–Axial MRI scan (TR SE 2000, TE 20) demonstrating extension of heterogenous mass into the right cerebellopontine angle cistern.

In general, chordomas affect both men and women equally in the 4th through 7th decades of life. Sacrococcygeal type is more common in males and has the greatest frequency in the 4th through 7th decades. Sphenooccipital chordomas have an equal sex distribution and generally occur in the 3rd through 6th decades.[4]

Most chordomas are malignant, being locally invasive with bony destruction occurring in 52 to 87% of the cases. Malignant chordomas metastasize in 10 to 48% of cases, and the most common

Fig 2.-Sagital (TR SE 500, TE 25) MRI scan showing the mass anterior to the pons and medulla.

sites are lungs, liver, and skeleton. Four percent of chordomas are considered to be benign.[5] Radiographically, evaluation of chordomas usually includes both CT and MRI. CT is considered better in demonstrating tumoral calcification and defining the exact anatomy of bony destruction. Tumoral calcification is secondary to dystrophic mineralization or engulfed osseous remnants, as seen in 30 to 70% of the cases. This finding, along with evidence of bony destruction, is considered to be characteristic of chordoma[6]. MRI is felt to be superior in defining the exact position of the brain stem relative to tumor and in providing information about tumor extension[7].

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Unilateral seminal vesicle cyst presenting as hematospermia; diagnosis established by transrectal prostatic ultrasound

J. S. Mayersak, MD, and Carl J. Viviano, MD, Wausau

A case report of a unilateral seminal vesicle cyst presenting as painless hematospermia in a 44-year-old patient is presented. Ultrasound-guided needle aspiration of the cyst demonstrated a markedly elevated LDH level in the cyst fluid of unknown significance. Antibiotic injection under ultrasound guidance into the seminal vesicle cyst was accomplished. Laboratory evaluation on the cyst fluid is suggested. *Wis Med J.* 1992; 91(11):629-631.

Although hematospermia is generally thought to be a self-limiting benign process, vigorous evaluation is recommended due to the potential for significant disease.[1] Hepatic disease, prostatic carcinoma and tuberculosis represent some of these disease processes. Mullerian duct cysts have been reported to cause chronic hemospermia. The diagnosis of mullerian duct cysts has been established by magnetic resonance imaging and by transrectal prostatic ultrasound.[2-4] With the availability of newer diagnostic imaging modalities, including transrectal prostatic ultrasound, the various causes of hemospermia can be property evaluated.

Using transrectal ultrasound to diagnose seminal vesicle calculi and cystic dilation of the seminal vesicles, Littrup and associates reported hematospermia to be a symptom of these conditions; 52 of their patients had abnormalities of the seminal vesicles or ejaculatory ducts detected on transrectal prostatic ultrasound.[5] Perineal or ejaculatory pain and hematospermia were clinical symptoms. Review articles of hematospermia and diseases of the seminal vesicles are available.[6,7]

A primary papillary tubular adenocarcinoma of the seminal vesicle in a 19-year-old with hematospermia was reported by Kawahara where the diagnosis was assisted by ultrasonography; paracentesis of the left seminal vesicle was performed under ultrasonographic control.[8]

Lamont and associates used transrectal ultrasound guidance in the biopsy of a angiosarcoma of the seminal vesicle in a 52-year-old complaining of coccygeal pain.[9] They also performed prostatic specific antigen and carcinoembryonic antigen studies on the tissue removed.

A proposed algorithm for the evaluation and management of prostatic and seminal vesicle cysts has been presented by Shabsigh and associates, which includes ultrasonographic guided needle aspiration of the seminal vesicle cyst fluid.[10]

Fuse and colleagues recommended the treatment of hematospermia by direct injection of antibiotics, hydrocortisone and coagulants under ultrasound guidance.[11] No malignant cells or bacterial growth were noted in the fluid removed from the seminal vesicles in any of their cases.

A classification of seminal vesicle cysts has been proposed previously.[12] The following case report represents a patient with an unilateral seminal vesicle cyst presenting as hematospermia.

Case Report

M.B., (Case No. 91L-15) a 44-year-old patient, presented in December 1990 to his family physician, citing a 6-month history of blood in his ejaculate. This was his only complaint. The patient experienced no pain with ejaculation.

Intravenous pyelography on Dec 12, 1990, showed incomplete filing in the lower pole of the left kidney but no evidence of ipsilateral renal agenesis.[13] Subsequent retrograde pyelography showed no abnormality. Serum prostate specific antigen and prostatic acid phosphatase levels were normal.

The patient was seen in urological consultation and the physician recommended transrectal prostatic ultrasound. On physical examination, neither seminal vesicle could be palpated and the prostate gland had the consistency of prostatitis.

Diagnostic transrectal prostatic ultrasound with a Teknar Proscan 7.5 MHz ultrasound imaging system was conducted Jan 8, 1991. Mid-prostate volume was normal (21.5 cm^3). Numerous hypoechoic areas were seen throughout the prostate gland consistent with prostatitis. Ultrasound-guided biopsies of the prostate gland demonstrated glandular and fibromuscular prostatic hyperplasia with prostatitis. On transrectal ultrasound, the right seminal vesicle was normal. The left seminal vesicle both in longitudinal and transverse scanning showed a marked cystic dilation (Fig 1 and 2).

A 22-gauge Chiba needle was introduced into the left seminal vesicle under ultrasound guidance. Six cubic centimeters of grossly blood fluid were aspirated, but not all of the fluid in the seminal vesicle cyst could be removed as determined by ultrasound.

Microscopic analysis, cytology, aerobic and anaerobic culture, and fat determination were negative. LDH determination on the fluid was 6,252 units/liter (Normal serum levels are 100-210 U/L).

Eighty mg of Garamycin was injected into the left seminal vesicle under ultrasound guidance. Intravenous antibiotic therapy was initiated on an outpatient basis to treat the prostatitis. The patient responded well.

When the transrectal prostatic ultrasound examination was repeated 14 days later, there was very little change in the size of the cystic dilation of the left

Dr Mayersak and Dr Viviano are with the department of surgery, urology section, at the Wausau Hospital Center. Reprint request to: J.S. Mayersack, MD, PO Box 177, Merrill, WI 54452-0177. Copyright 1992 by the State Medical Society of Wisconsin.

seminal vesicle. The patient continued to have intermittent hematospermia for approximately 2 months, then the condition ceased. No further ultrasound studies were performed.

Discussion

A case report of hematospermia, in a 44-year-old patient, felt to be secondary to a unilateral cyst of the left seminal vesicle is reported. There is no relationship between the ultrasonographic characteristics of the seminal vesicle and post ejaculation condition so that the dilation of the seminal vesicle was indicative of an actual problem with the seminal vesicle.[14] Aspiration of fluid from the seminal vesicle demonstrated a markedly elevated LDH level at 6,252 IU/L.

Hein and colleagues did not find any marked degree of elevation of the LDH levels in prostate fluid obtained from their patients by massage.[15]

Srivastava and associates did not report any significant elevation of LDH in human seminal plasma in their study of normal controls and azoospermic and infertile males.[16]

Rosecrans and associates reported that all the biochemical constituents in seminal plasma were significantly higher than in blood serum. The mean LDH level in serum was 89.6 IU/L and in seminal plasma the level was 1,966.8 IU/L.

These studies were performed on 24 "normal" volunteers and represent what would be probable normal values to serve as a baseline for evaluation of fluid obtained by needle aspiration. The fluid removed from the seminal vesicle was negative for bacterial growth or evidence of tumor. Prostatic needle biopsies demonstrated no evidence of carcinoma but prostatitis was present. This is felt to represent a case of obstruction of the ductal system from the left seminal vesicle, most likely acquired secondary to prostatitis.[18] There was no ipsilateral renal agenesis associated with this seminal vesicle cyst as is commonly encountered.

Needle aspiration of the fluid from such seminal vesicle cysts can be performed under ultrasound guidance and may be beneficial if bacteria can be demonstrated on culture studies or gram staining. The clinical response to injection of antibiotics into the seminal vesicles has not been dramatic as reported in the literature. The evaluation of the fluid may include aerobic and anaerobic culture, cytology, fat determination, and LDH determinations. Prostate specific antigen and prostatic acid phosphatase evaluation of the aspired fluid may also be merited. Antibiotic therapy although decreasing the incidence of hematospermia had little effect on the size of the cystic dilation in the seminal vesicle. Transurethral drainage of the seminal vesicle by resection of the verumontanum or dilation of the ejaculatory duct

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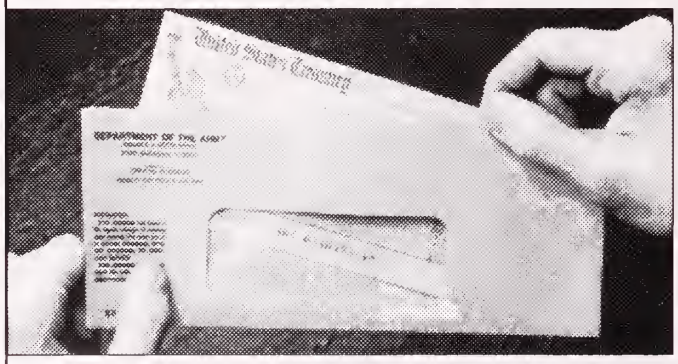

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may be a more appropriate treatment.

With greater use of diagnostic transrectal prostatic ultrasound by urologists, physicians can expect to encounter more cases of this type of cystic dilation of the seminal vesicle associated with hematospermia.

Other causes of hematospermia may also be discovered with the use of transrectal prostatic ultrasound. The diagnosis and proper treatment of cystic dilation of the seminal vesicle is subject to variation and considerable differences of opinion exist among physicians in regard to the management of the problem.

Depending on the experience of the physician and the response of the patient, however, transrectal intraseminal vesicle injection of drugs as advocated by Fuse seems to be an additional modality of therapy which should be considered in some cases. It may be appropriate to perform gram staining of the fluid removed from the seminal vesicle before the antibiotic injection. The significance of the elevated LDH level in the fluid from the seminal vesicle in this case is not known.

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Public health

The increasing health and economic burden from cigarette smoking in Wisconsin

Nancy Chudy, MPH; Patrick L. Remington, MD; and Richard Yoast, PhD, Madison

During the past decade, public health advocates have documented an increasing health and economic burden from cigarette smoking. In 1978, the US Surgeon General estimated that 300,000 Americans died annually from smoking-related diseases.[1] By 1988, this had increased to 435,000–1 out of every 5 deaths.[2] More recently, studies have examined the health effects of environmental tobacco smoke (ETS) on the health of non-smokers. Currently, ETS is estimated to cause 3,800 deaths due to lung cancer and 35,000 deaths due to heart disease annually in non-smokers.[3,4]

Methods

To estimate the health and economic burden from tobacco use in the state, we used the SAMMEC II (Smoking-Attributable Mortality, Morbidity and Economic Costs) software program distributed by the Centers for Disease Control. The analysis used 1990 census and mortality data, 1989 Current Population Survey smoking prevalence rates, and 1987 Health Care Financing Administration expenditure data. Results of this analysis were extrapolated to the present, using 1992 population estimates. Losses from pain and suffering were not included.

We estimated the number of deaths attributable to environmental tobacco smoke in Wisconsin by multiplying the national annual estimates by 2% (Wisconsin's percentage of the US population). We compared the smoking-attributable mortality, morbidity, and economic costs estimates for 1992 with previously published estimates for 1985[5] and 1988.[6]

In estimating the economic costs of smoking, both direct and indirect costs were determined for those who died from

Continued on next page

Table 1.—Smoking-attributable deaths by selected disease categories, Wisconsin 1985-1992.

Disease Category	1985*	1988**	1992
Cardiovascular diseases	2,535	3,713	3,605
Cancers	1,870	2,465	2,650
Chronic obstructive pulmonary diseases	1,145	1,655	1,660
Perinatal conditions	—	34	34
Burns	—	33	35
Environmental tobacco smoke	—	—	776
Total	5,550	7,900	8,760

* See Reference 5.
** See Reference 6.

The public health column is not reviewed by the *WMJ* Editorial Board. Chudy is an epidemiologist in the Section of Chronic Disease and Health Assessment. Dr Remington is the chief medical officer and state chronic disease epidemiologistin the Bureau of Public Health. Dr Yoast is the project manager for ASSIST Wisconsin, Wisconsin Division of Health. Part of this work was made possible through a contract with the National Cancer Institute (N01-CN-15373) for the ASSIST Project. Reprint requests to: Patrick L. Remington, MD, Wisconsin Division of Health, 1400 E Washington Ave, Madison, WI 53703-3041. Copyright 1992 by the State Medical Society of Wisconsin.

Continued from preceding page
neoplasms and cardiovascular, and respiratory diseases. Direct cost estimates included costs for diagnosis, treatment, prevention, and rehabilitation of smoking-related diseases. Cost estimates for hospitalizations, outpatient care, physician or other health professional services, nursing home care, and medications were included. Indirect costs of smoking were measured by lost income or productivity, or illness due to smoking-related diseases, either through death or illnesses.

Smoking-attributable mortality estimates are based on persons 35 years and older, except for those related to burns and perinatal conditions.

Table 2. – Smoking-attributable economic costs (in millions), Wisconsin 1988-1992.

Costs	1985*	1988**	1992
Direct	$470	$303	$ 321
Indirect mortality	$267	$465	$ 606
Indirect morbidity	$166	$ 99	$ 109
Total	$903	$867	$1,036

* See Reference 5.
** See Reference 6.

Results

In 1992, we estimate that 8,760 Wisconsin residents will die from tobacco-related diseases (Table 1). Of these deaths, approximately 776 non-smokers will die from diseases related to environmental tobacco smoke. Of the balance, about 41% of the deaths will be due to cardiovascular diseases (heart disease, stroke, and atherosclerosis); 30% due to cancers (lung, oropharyngeal, pancreas, bladder, kidney, and cervix); and 19% due to respiratory diseases (chronic obstructive pulmonary disease, bronchitis, emphysema, pneumonia or influenza, and respiratory TB).

The smoking-attributable mortality from cancers, respiratory diseases, and other conditions has increased substantially during the past 7 years, from 5,550 in 1985 to 7,900 deaths in 1988, and more than 8,700 deaths in 1992. In 1992, total costs exceeded $1 billion, with $321 million in direct costs, and $715 in indirect costs (Table 2). This increase from prior years is due to the marked increase in indirect mortality costs (loss of future earning from premature deaths), which have steadily increased since 1985.

Comment

The data presented in this report demonstrate an increasing burden from tobacco use in the state. The increase in the number of deaths over the 7-year period may be due to various reasons. First, new methods of analysis were employed since 1985. The SAMMEC II software has been updated with more precise risk estimates.

Secondly, the analysis of smoking-attributable deaths shows increases each year due to the inclusion of other causes. From 1985 to 1988 smoking-attributable mortality was expanded to encompass perinatal conditions and residential fire deaths. Maternal smoking during pregnancy has been associated with low birth weight, pre-term births, and respiratory distress syndrome. Residential fires cause most fire-related deaths, and cigarettes are the largest cause of residential fires.

Lastly, the increase in mortality from 1988 has been due to the recognition of the health effects of ETS. The health effects of ETS have been reviewed extensively in epidemiologic literature, in reports by the surgeon general,[7] the National Research Council,[8] and the Environmental Protection Agency (EPA).[9] Environmental tobacco smoke has been classified as a Group A carcinogen, an agent known to cause cancer in humans, by the EPA. ETS is a combination of sidestream smoke from burning cigarettes and exhaled mainstream smoke from smokers. Currently, there is no safe level of exposure. Active research indicates that ETS exposure is causally associated with lung cancer and increases the risks of ischemic heart disease among non-smoking adults.

ETS is associated with other health effects, not accounted for in this analysis. Serious effects have been described in children raised in smoking households. Children exposed to ETS have been shown to experience an increased prevalence of acute lower respiratory tract infections (bronchitis, pneumonia), respiratory symptoms of irritation (cough, wheeze), and middle ear effusions (chronic middle ear infection indicator).[9,10]

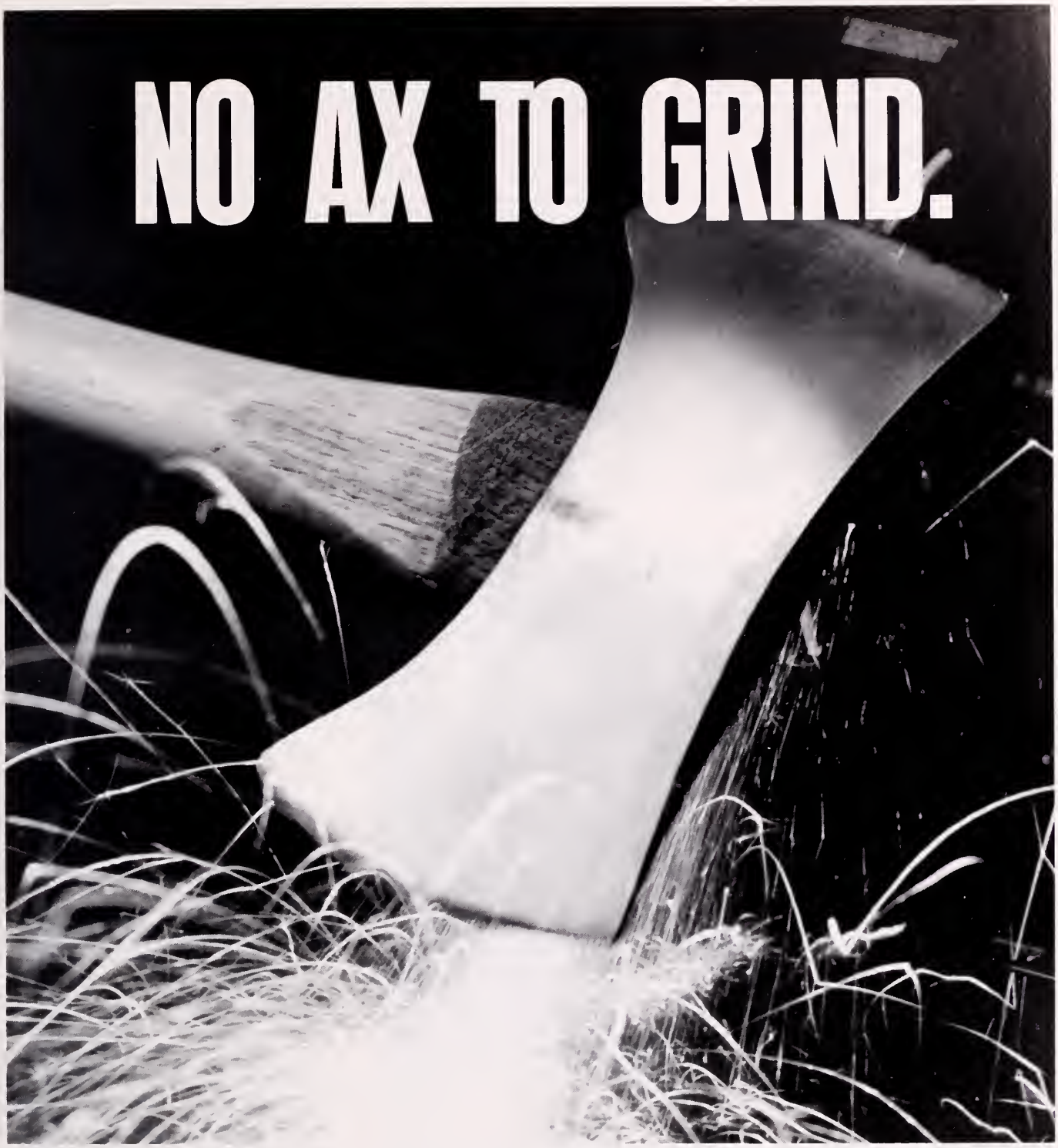
What needs to be done to reduce this health and economic burden? First, efforts should continue to be directed to help smokers in their attempts to quit. Activities and support for adults who want to quit smoking, especially parents of young children, include health care provider screening and referral, provision of cessation programs, increases in excise taxes, and reductions in insurance rates for non-smokers. In addition, policy changes to restrict smoking, and to provide smoke-free environments, such as in public places and workplaces, will provide a supportive environment for smokers in their efforts to quit.

Second, we should continue to prevent children from starting to smoke. This can be accomplished by supporting smoking prevention activities for youth, implementing comprehensive school health education curricula, restricting promotional and free-giveaway activities targeting youth, and limiting youth access to tobacco products.

Finally, the health burden from ETS should be reduced. According to the National Institute for Occupational Safety and Health, workers should not be involuntarily exposed to tobacco smoke.[11] The best method for controlling worker exposure to ETS is to prohibit tobacco use at the workplace and to implement a smoking cessation program. The simple separa-

Continued on page 636

NO AX TO GRIND.



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Continued from page 634
tion of smokers and nonsmokers with the same airspace may reduce, but does not eliminate, the exposure of non-smokers to ETS.

The devastating health and economic impact of active smoking and, now, the health effects of environmental tobacco smoke on non-smokers, have underscored the importance of smoking prevention and cessation as a major public health priority. Opportunities exist for physicians in offices, hospitals, professional organizations and communities to have an impact on public policy and in the reduction and control of smoking-related diseases.

Acknowledgments
Gianfranco Pezzino, MD, assisted with the data analysis and reviewed the article.

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Medical Assistance to offer prenatal care coordination as benefit

In an effort to improve prenatal care access and birth outcomes for high-risk pregnant women, the Wisconsin Medical Assistance Program will begin offering prenatal care coordination as a separate benefit in January 1993. Certified prenatal care coordination agencies will assist high-risk pregnant women in getting the care they need by making referrals and appointments, arranging for services such as child care and transportation to help them get there, and checking to see that participants understand and are following their physicians' instructions. The MA program is asking physicians who provide obstetric services to consider discussing possible referral relationships with local prenatal care coordination agencies.

Care coordination agencies are about to begin their MA certification process. To meet certification standards, they must show, among other things, that they have agreements with prenatal care medical providers in their area to refer pregnant patients for prenatal care. These agreements are crucial because the central goal for care coordination agencies is to assure that patients get early and regular prenatal care. Care coordination agencies will assist referral physicians by making sure that patients show up for medical appointments. Staff work with patients to help them reduce risky behaviors such as drinking alcohol and smoking during pregnancy.

The SMS Committee on Maternal and Child Health and the SMS Medical Assistance Technical Advisory Committee have discussed prenatal coordination and contributed to the development of the risk assessment questionnaire. Numerous studies have shown comprehensive prenatal care coordination to be effective in increasing birth weight and improving other birth outcomes. Recent experience from 11 Wisconsin demonstration projects confirms this premise.

A Wisconsin medical team travels to the Dominican Republic

Peter J. McCanna, MD; Patrick J. Saine, MEd, CRA; Paul Mullaney, MD; Pamela Avery, MD; Carol Czomak, RN; and Margaret Helin, RN, Madison

A WISCONSIN OPERATING TEAM evaluating patients outdoors in January? In 80° weather? Unbelievable, but true. For the past 2 years, physicians and other health care professionals from Madison have traveled to the Dominican Republic to perform eye surgery. This article describes team members' experiences and offers tips for those considering a Third World medical mission.

An adjustable suture procedure is performed with local anesthesia on a young girl.

A nurse's perspective

In early 1990, our first surgical trip to the Dominican Republic was only a dream. It was conceived by Dr Tom Mescher after a religious retreat to Elias Pina, a small village about a mile from the border of Haiti in the Dominican Republic. The Catholic diocese of Green Bay sponsors a missionary parish, staffed by two Wisconsin priests, in this village. On his return to work, Dr Mescher shared that dream with the staff of Davis Duehr Eye Associates to see if he could get the support to accomplish such a trip. It sounded like such a challenge and an adventure! Could we really perform high tech surgery in an area that did not have dependable electricity or running water?

We knew that all of our equipment and supplies would need to be carried in, that we had a building to use, and that the priests would feed us and give us a place to stay. For the first 6 months of 1990 we tried to get this project on its feet with very little success.

Where could we get a microscope, autoclave, generators, and miscellaneous exam equipment? How could we transport it 5 hours into the mountains? And would the government officials let us into the country and allow us to perform surgery? We concluded that we needed a contact within the Dominican Republic.

We found the people at the Christian Medical and Dental Society (CMDS) were happy to help us. They had a microscope, autoclave, operating tables, and slit lamp. They would arrange for our entrance into the country and transportation to Elias Pina, and would also screen potential

Saine and Dr McCanna are with Davis Duehr Eye Associates in Madison. Czomak and Dr Mullaney are with the University of Wisconsin Hospital and Clincis in Madison. Helin and Dr Avery are with the Ambulatory Anesthesia Associates in Madison. Reprint requests to: Peter J. McCanna, MD, Davis Duehr Eye Associates, 1025 Regent St, Madison, WI 53717. Copyright 1992 by the State Medical Society of Wisconsin.

What does the future hold for Dominican children such as these?

Continued from preceding page
patients. At last, it seemed that we were well on our way.

We had given the people at the CMDS a tentative date of the third week of January for our trip. When we could not seem to get a firm commitment from them by October, we became discouraged and concluded that this trip might not take place after all. We were disappointed, but decided that if it was meant to be, then it would all work out. Early in December, we got the call that they were expecting our arrival in January. This was our first realization of the contrast between the American and Dominican culture. Through this interaction, we learned to be patient and have respect for the differences between our cultures.

The first year, one surgeon, two anesthesiologists, two nurses and an ophthalmic photographer made the trip. Cataract extraction was our only planned surgery.

Our 1992 team included two physicians, four nurses, one anesthesiologist, an OR technician and an ophthalmic photographer. This year, we saw more than 300 patients and performed 59 surgeries including cataracts, strabismus, pterygiums, and trabeculectomies. We worked 10 to 12 hours each day for 4 consecutive days. Our surgical suite had two beds, a single microscope and one light. At times, we were able to conduct two surgeries simultaneously.

In preparation for the venture, we contacted individuals experienced in Third World surgery for advice. We also gained several pointers from the CMDS, learning to divide a large room into smaller work areas by stringing rope across the room so we could hang sheets as dividers.

We established our examining and surgical suite in the church recreation building. Church benches topped with mattresses served as our pre- and post-operative beds. For our operating room, we cleaned a room thoroughly, then nailed paper surgical drape sheets to the concrete block walls using strips of cardboard. Open areas between the top of the walls and the corrugated metal roof were stuffed with paper to keep out the dust.

We knew we would have to plan for all our needs, because supplies would not be available in a Third World country. Portable generators were a must, because electrical service is unreliable. To reduce the amount of supplies we would have to carry in, we opted not to bring surgical gowns. (We found it's too hot in the Dominican Republic to wear gowns anyway.) Hexachlorophene foam products proved invaluable for hand scrubs when running water was unavailable, and acetone served as very acceptable disinfectant for instruments. The autoclave was quite unreliable.

As most companies have a contact person who handles donations, we found obtaining donated supplies was easier than we had believed.

When we arrived, Elias Pina had not had rain in more than 3 months. We scrubbed using two basins, one with clean water and the other to catch the dirty water. Cups of clean water were poured over scrubbed arms.

Before going on such a trip, it is advantageous to learn about the culture and the life of the people. In the Dominican Republic, for instance, the people cannot follow even basic health guide-

lines. How can you boil your water when you have no wood to build a fire, and only a small amount of charcoal to cook what little food you may have? We saw many patients with untreated diabetes, hypertension, and glaucoma. But even if these diseases are diagnosed and people are given medication, the help is only short-term. When the medicine is depleted, refills are not available.

A knowledge of the language is helpful–we were lucky to have good interpreters. If you are considering a medical mission to a Third World country, plan on working hard. None of us could be paid to work as hard as we did. Be ready to shower in cold water and be happy because at least there is water in the mains. Take along some non-perishable snack food. Wear comfortable clothing; skirts are more appropriate for women. Take time every day to reflect on what you have done, and always remember that you are a guest in their country.

A surgeon's view

What do you do when you come into work at 8 AM only to find that you are already 80 patients behind? This was what we faced on our first day at the clinic in Elias Pina.

We established triage, assigning patients consecutive numbers, then checking their visual acuities and recording information on a clinic sheet. Patients kept this "record" with them throughout their visits. After chief complaints were recorded, we examined patients briefly using a flashlight to examine the anterior portions of the eye and check the pupillary response to light. Often, this examination was sufficient to diagnose external diseases. Pterygium, a conjunctival growth which extends into the cornea, was a common complaint and familiar to many patients. Only those patients with pterygia impinging on or covering the pupillary margin were scheduled for surgery.

Numerous patients complained of poor vision from traumatic or infectious corneal scars, but we could do nothing for those conditions as corneal transplant requires donor tissue and prolonged follow-up, both of which we were not able to provide. Mature cataracts could be diagnosed by a white pupil, and these were very common. Almost all patients on whom we operated had bilateral mature cataracts.

The number of younger patients with cataracts was also remarkable–the saddest was a 4-year-old boy with one eye blind from a corneal scar (probably measles, keratitis or vitamin deficiency) and the other eye blind from a mature cataract.

Strabismus patients were easily identified and referred to my associate, a fellow in pediatric ophthalmology, for further work-up and surgery.

The disposition of glaucoma patients was much more difficult. Patients with glaucoma who see well enough to require only medical therapy do not have access to, and cannot afford, the required medications. Their disease, however, is too early for surgical intervention.

Patients who have a blind eye from glaucoma and good vision in the fellow eye with high intraocular pressures could not understand why the eye that sees well could be operated, rather than the eye with poor vision.

In patients who have end-stage disease, bilateral glaucoma surgery would only be preserving minimal vision and our time might be better spent in removing a cataract in a patient with the potential to regain functional vision. We felt that–despite laborious consultation–patients who were operated on for glaucoma would be disappointed that their vision had not improved.

Patients showed a wide variety of pathology, including corneal scarring from trachoma, vitamin deficiency, measles, and trauma. We also saw cases of: retinitis pigmentosa, bilateral central retinal artery occlusions, Coat's disease, retinal detachments, descemetoceles, vein occlusions, optic atrophy, and interstitial keratitis.

Due to the generosity of many medical supply vendors, we were well equipped for the surgical aspect of our trip. The CMDS provided an operating microscope. Disposable supplies–from intraocular lenses to irrigating cannulae–were available.

We removed cataracts using the extracapsular technique with manual aspiration and placement of posterior chamber lenses. The only inconvenience was using instruments somewhat different than the ones used in Madison. The periodic lack of electricity gave our surgery an unfamil-

Continued on next page

A flashlight examination in the courtyard. Many patients had other health problems.

Continued from preceding page
iar feeling of suspense.

I know our brief stay in Elias Pina benefitted those we treated, but it was equally rewarding for us, putting a new perspective on the quality of life and medical care we enjoy here at home.

A pediatric ophthalmic surgeon

My initial response to an invitation to accompany an ophthalmological team to the Dominican Republic was one of foreboding. How do I operate on strabismus with only one pre-operative measurement? What about the post-operative care? As it turned out a lot of my worries evaporated after I arrived.

I was surprised by the number of people of all ages with complicated, untreated strabismus. All patients had age-appropriate visual acuity testing, measurement of versions and strabismus. After pupillary assessment, a full cycloplegic refraction was performed. History taking and examination were performed through an interpreter. Generally this worked well, although some misunderstandings occurred. In the future, it may be useful to have someone read a relevant information sheet to patients prior to the examination.

Surgery under general anesthesia was performed on all strabismus patients under age 10. We used uniocular retrobulbar anesthesia with adjustable sutures for all patients older than 10 years, and were amazed at how stoic the patients were.

The strabismus population we treated can be divided into groups: the amblyogenic group under 8 years old, and the adult group requiring a basically cosmetic result. In the latter group, one pre-operative measurement is probably enough when combined with the use of adjustable sutures to "fine tune" the results. These patients do well under local anesthesia, although for patients with large deviations, physicians should consider operating on the fellow eye under topical anesthesia with local anesthesia infiltration.

For those under age 8, the picture is far from clear. Generally all children should be refracted, given the relevant prescriptions and be free of amblyopia prior to surgery to have the best results. In this population glasses are hard to come by, however, and often are associated with stigma. Compliance with occlusion for amblyopia treatment would not be possible due to the social environment.

So, does one operate on children who will not receive pre-operative treatment, or does one leave them with the butt of "evil eye" derision? I feel that each case must be judged individually, with reference to each patient's access to ophthalmic care. The parents of the two amblyopic children under my care understood

A Dominican youth. Is his future as bright as his eyes?

Buckets of water were boiled at the rectory and walked across the street to be used for scrubbing.

the importance of amblyopia management and were able to access ophthalmic follow-up once the surgery was performed.

Another worry with this age group was that variability could not be assessed with one measurement and could not be compensated for with adjustable sutures. There is also, in both groups, the worry of post-operative infection and absence of follow-up personnel.

Overall, I found the trip extremely exciting, confronting the dilemmas discussed above was challenging–if not a little nerve wracking. Fortunately there were no major problems.

A young Dominican awaits strabismus surgery.

Anesthesiology

The task of securing anesthetic supplies for an environment with no running water and intermittent electrical current was certainly a challenge. We came prepared to perform peribulbar nerve blocks for most of the adult and older teenage patients–the safest approach, we felt, with our limited resources. For the younger children who would require general anesthesia, we determined that a mask induction of halothane, oxygen and nitrous oxide was most practical and dependable.

The amount of equipment and supplies available on site was limited. We did know that we would have an anesthesia machine, although a most basic model of rather dated vintage. Oxygen would be available in limited amounts. Nitrous oxide was a scarce commodity. We needed to bring adequate amounts of volatile gas such as halothane, disposable tubing, canisters of SodaSorb and airway management equipment.

Drugs were all transported with us as well as IV equipment and fluids. We took no scheduled drugs and relied on gases and acetaminophen for post-operative analgesia. We also did not routinely use IVs, for several reasons. The large volume would have been difficult to transport considering our limited baggage allowance. Functioning as a totally free-standing ambulatory facility, we had limited nursing and technical staff available. Our post-operative nursing staff also functioned as pre-operative screening staff, making monitoring and care of IVs difficult at best. In retrospect, IVs would have been useful, and would have helped prevent the fluid depletion induced by the tropical climate. Also, a predominantly IV anesthetic would have produced faster wake-up times, less nausea, and generally more alert patients at discharge time.

Monitoring equipment consisted of a traditional "finger on the pulse" technique, precordial stethoscope, and a battery-operated pulse oximeter. Much to our delight, there was an ECG monitor and automatic blood pressure device available to us, though rarely could we get an adequate tracing on the ECG monitor. Most of the equipment found in Third World countries is older, outdated, and donated. (A good rule of thumb when donating equipment is to remember that if it didn't work properly in the United States, it isn't going to work any better in a Third World country where service and repairs are nonexistent.)

The patients were a delight to anesthetize. The children in the Dominican Republic are adorable. Besides being attractive and well-kept in appearance, they were very trusting and unafraid. We had only two children cry during the induction of anesthesia. In general, they walked into the operating room, climbed up on the table, and had a pleasant induction of anesthesia. The adults were very stoic, tolerating amounts of discomfort without sedation that many of our patients in the United States would not. They were also very tolerant of our "gringo" ways. Even my limited Spanish skills seemed to be appreciated by both children and adults. They never laughed when I inadvertently told them I would put *gatos* (cats) in their eyes instead of *gotas* (drops).

During the 4 days of surgery, 12 procedures were performed under general anesthesia and 24 were performed with the peribulbar technique. An additional 23 procedures were done with local infiltration alone. No children were anesthetized under the age of 2 years.

A photographer's perspective

My primary responsibility as the group's photographer was to observe and document. Watching the local lifestyle, the interaction between cultures, and the medical procedures, I can summarize my observations in one word: Simplicity.

Life in Elias Pina is a simple proposition. In a poor, increasingly deforested, remote, and mountainous region of the Dominican Republic, everyone has very little. Unpurified water runs twice daily. The luxury of electricity is provided only in the mornings and evenings. The chickens are skinner than any I'd ever seen.

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The local people saved the plastic bags and sheets that our supplies were packaged in–confident they could somehow make use of what we ignorantly discarded. The contrast between their poverty and our wealthy and wasteful way of life was simply astounding.

The Dominican people displayed a simple and honest trust for our group of *medicos*. I saw no bureaucratic regulatory body dictating parameters, no litigious faction ready to condemn, no third party paperwork. What I saw firsthand was the distillation of why many chose their health-related careers. I saw the simple beauty of people helping people.

Stepping back to take a reality check, I don't want to imply that we, like Paul Gauguin in Tahiti, found paradise on a tropical island. I would, however, encourage all to make a trip like this at least once in their career. Your perspective on life and health care will be forever altered.

Should you have a chance to participate in a trip like this and wish to document it, I would again suggest simplicity. A mid-priced auto-focus camera with a flash will fulfill the needs of many. Small size and ease of use are important considerations. A medium speed film (100 or 200 ISO) should be adequate if flash is used indoors.

For those more experienced in photography, an interchangeable lens single lens reflex may be the camera of choice. I would encourage you to pack a minimum of lenses, as lens changing decisions tend to slow down the photographic process. A medium speed film will work outdoors, but also pack a fast film (1000 ISO or higher) because indoor lighting is typically weak or nonexistent.

When choosing film, consider both the conditions under which you will be shooting and the final use of your image. You may want to select a black and white print film if your intention is to publish your photographs. Choose a slide film if you intend to share your experiences with groups.

Avoid exposing your film to x-rays, especially at foreign airports. I unload my camera and keep both my exposed and unexposed film in a clear plastic bag. My experience has been that security officers are more willing to inspect your film if they can x-ray your equipment.

Make time during your trip to concentrate on taking pictures. Take more pictures than you think you'll need. Don't forget to document simple, everyday things, as well as those exciting experiences and interesting sights. You will be surprised at how quickly you can forget your "trip of a lifetime" without some photographs to remind you of just how things were.

Conclusion

What started out as a challenge and an adventure turned out to be a very spiritually rewarding experience. These are wonderful people who accepted our help with grace and dignity. Coming home can be a culture shock. All the things we take for granted seem like such luxuries. Don't plan on going just one time. It's addictive.[15th]

Providing health care for the Hmong

David A. Waters, MD; Rama B. Rao, MD; and Helen E. Petracchi, PhD, Milwaukee

In 1975, the United States completed its full military withdrawal from Southeast Asia and ended its direct participation in the armed conflict against the communists. As a result, hundreds of thousands of Hmong people who fought on the side of the United States were forced to flee Laos to escape persecution by the communist Pathet Lao. The Hmong fled to the countries bordering Laos, primarily Thailand, and abroad to the United States and other western countries.

More than 100,000 Hmong have resettled in the United States since 1975. Approximately half of the US Hmong refugee population resides in California. Wisconsin currently has the country's third largest Hmong population, with 16,373.

Even though Hmong refugees have been living in the United States for nearly 2 decades, many US health care providers know little about the Hmong people and their history, culture, beliefs, and practices.

By increasing our cultural awareness and sensitivity, health care delivery and outcomes will undoubtedly improve, as will the satisfaction of both the Hmong patients and their health care providers.

An overview

The word "Hmong" means "free men." Independence and self-reliance characterize the Hmong people. Originating in China, the Hmong are an ethnic group distinct from the Chinese. Many Hmong left China in the late 19th century to escape subordination by the Chinese. Fleeing to Southeast Asia, the majority settled in the mountain regions of Laos.

Village life. Living in isolated villages, the Hmong had little contact with the outside

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world and were free to pursue their traditions and ways. They produced food by farming and employed the slash and burn method to clear fresh land when the farmed soil became exhausted. They raised livestock which were used for food and for sacrificial purposes in their religious ceremonies. Hunting was another means of sustenance.

The clan. Traditional Hmong society is male dominant and organized into large, closely knit communities known as clans. Each clan includes many extended families and is headed by an elder male leader. All the families and individuals in each particular clan have the same last name. Examples of clan names include Xiong, Yang, Lee, and Vang. The clan leader is revered and provides advice and the final word in making decisions and resolving problems for the members of his clan.

In Hmong society, the well being of the clan and the family takes priority over that of any individual member, and the clan leader's decisions will reflect what he perceives is best for the clan as a whole.

Like other Eastern cultures, respect for the elderly and for authority is taught and emphasized by the Hmong.

Hmong people tend to be reserved and have been described as having a passive-obedient manner. Stoicism and reluctance to express strong emotions are other recognizable cultural traits.

Spiritualism. Animism and ancestor worship are integral to the belief system of traditional Hmong culture and influence nearly every aspect of their daily living. Their relationships with the good and evil spirits are paramount. In Laos, the site and position of their homes and fields are carefully selected to ensure the favor of the spirits. Chants, ceremonies, and animal sacrifice are used to maintain harmony with their ancestors, nature, and the other spirits.

The string bracelet worn by many Hmong children is given to them as a blessing by their elders. It is believed to connect them to the spirit of their ancestors and prevents their souls from escaping their bodies.

Like many people in Eastern cultures, the Hmong believe in predetermination and reincarnation. A person's life span and fate are set at birth and cannot be altered. Events and actions in this life are viewed in the context of how future lives

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will be positively or negatively affected. There is an expectation that a person will have less suffering in his or her next life. People, animals, plants, natural phenomena, and inanimate objects are all believed to possess souls and, therefore, are respected.

Stemming from Chinese influences, the Hmong also believe in the yin-yang concept of opposing natural forces. As a result, they strive to maintain balance, equilibrium, and bodily warmth.

Traditional healing. Similar to the Native American medicine man, the Hmong shaman is a very important figure in Hmong society and serves as the people's intermediary between the physical and spiritual worlds. The Shaman can be either a man or a woman. They use trances and elaborate ceremonies to communicate with the spirits, and they oversee the clan's spiritual, mental, and physical well-being.

The herbalist is another highly respected clan member who uses herbal remedies to treat physical and mental ailments and imbalances.

Folk medicines and practices are used by the Hmong to treat many perceived or actual maladies. Dermal abrasive techniques such as coining, cupping, pinching and spooning are traditional healing methods and should not be mistaken for signs of child abuse. Other traditional methods include acupuncture, burning, and blood-letting. Powders, potions, massage, steam treatments, and maintenance of hot-cold balance may also be employed.

Through contact with missionaries and other influences, many Hmong have converted to Buddhism or Christianity. This may affect which traditional Hmong practices they use or consider acceptable.

Marriage customs. In traditional Hmong society, people usually marry at a young age, and most marriages are arranged by their families or the clan elders. Members of the same clan are forbidden to marry one another. A woman keeps the surname of her clan after marriage. Occasionally, a Hmong male kidnaps a woman from another clan and makes her his bride. While this had been viewed as an acceptable practice in Southeast Asia, it has posed obvious problems for Hmong males who have attempted to continue this custom in the US.

Marriages produce many children, which serves to offset the high infant and childhood mortality rates experienced by the Hmong living in Laos. Also, the Hmong believe that infants provide a body for the soul of a deceased ancestor seeking reincarnation.

Adolescence. Adolescence, a complex developmental phase, hardly exists in the Hmong world of Laos where individuals pass almost directly from childhood to adulthood. Having had minimal experience with adolescent behavior, it is understandable that Hmong parents might be even more bewildered than American parents by their adolescent child. At the same time, many American Hmong adolescents are experiencing conflict between peer acceptance and their family's expectations for them to adhere to traditional ways.

The Hmong odyssey

The Hmong involvement in the armed conflict in Southeast Asia began in the early 1950s when they were recruited by the French to serve as scouts in the escalating struggle against the communist forces. When the French occupation of Laos ended in 1954, several opposing factions fought to assume power. Many Hmong participated in the pro-Western actions against the Pathet Lao communists.

As the United States became involved in the war in the 1960s, the CIA recruited the Hmong to act as a "secret army." Hmong soldiers were reportedly very courageous fighters and sustained large numbers of casualties.

The Hmong exodus. In 1975, when the US military made its final withdrawal from Southeast Asia, a huge number of Hmong were emergently evacuated out of Laos and brought to the United States. Many more pro-Western Hmong were left behind to face the brutal revenge of the Pathet Lao. Thousands upon thousands were tortured, raped, and murdered. Those who escaped were forced to flee their homes and villages. Families traveled hundreds of miles on foot through the jungle. Their journey saw many hardships including starvation, illness, separation, injury, and death. Capture by communist forces meant extermination.

To escape from Laos to Thailand, they had to cross the Mekong River, either by swimming or in makeshift boats. Thousands drowned or were shot by soldiers while attempting the river crossing. Hmong folk art pieces frequently depict the story of their exodus from Laos.

Refugee camps. Those Hmong who succeeded in reaching Thailand have been interned in Thai refugee camps. The camps are overcrowded and have inadequate food, water, supplies, and facilities. Morbidity and mortality are high. Families wait months or years before being granted exit visas to the United States or one of the other Western countries that will accept them. Having a sponsor (usually family, or a religious or social service organization) in a country is required before the request for emigration will be considered.

The Hmong in America. The adjustment to life in America has resulted in yet more trauma for many Hmong families. Late 20th century high-tech America is an overwhelmingly different world from the isolated mountain existence the Hmong once knew. Resettlement by sponsoring agencies has primarily been in urban areas, many located in colder climates. Communication difficulties and dependency on governmental and community agencies are additional stressors for these new immigrants. Even worse than culture shock, many Hmong suffer from depression and post-traumatic stress disorder as a consequence of their tragic experiences.

Cultural awareness

Understanding, respecting, and acknowledging the beliefs and practices of an ethic group are vital to providing quality health care to that group. Patient compliance, trust, and health outcomes will

improve accordingly. And the level of satisfaction experienced by both the patient and the medical provider will increase, while the chances of frustration, aggravation, and confrontation will be lessened. Learning about different people and cultures can be a source of enrichment for Western medical personnel.

As physicians, we must guard against stereotyping our patients or making generalizations about patient populations. Within the Southeast Asian refugee population residing in the US are Hmong, Laotian, Vietnamese, Thai, and Cambodians, all distinctly different groups. Each contains a wide spectrum of individuals ranging from those who are very assimilated to Western culture at one extreme, to those who strictly maintain the traditional ways at the other.

Factors affecting a person's acculturation include, length of time in the United States, education, occupation, previous exposure to Western ways prior to arrival in the United States, and the strength and influence of their family and their clan. Every patient and every patient encounter needs to be individualized.

Hmong health care

Having emphasized the importance of cultural awareness and sensitivity and the need to individualize every patient, there follows a discussion which contains many generalizations about the Hmong and their relationship with our health care system. The degree to which all, some, or any of this information applies will vary from patient to patient.

The Hmong in Laos. It generally takes time, patience, and ongoing positive interactions for Western providers to establish rapport with their Hmong patients. Hmong suspicion and mistrust for medical personnel largely results from having had little or no contact with Western medical practices while in Laos. Many doctors there were poorly trained, medical facilities were ill-equipped, and access to care was limited. What contact the Hmong had with doctors frequently resulted in bad or even deadly outcomes. People often went to hospitals already quite ill and only as a last resort after traditional healing methods failed. Many times, they did not return. Hospitalization came to be viewed as a final step before death and many Hmong still fear hospitals.

Many Hmong believe that they were used as subjects for experimentation by Laotian medical students and are still distrustful of teaching institutions.

Fear of surgery and autopsy. Commonly, Hmong patients are hesitant to undergo surgery or refuse it altogether. With their belief in reincarnation, it is thought that body parts surgically removed will be missing in a person's reincarnated form

Continued on next page

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Continued from preceding page
in their next life. Also, opening the body with a surgical incision is thought to provide an avenue for evil spirits to enter one's body. Finally, surgery in Laos often resulted in disability or death and is, therefore, avoided.

Similarly, autopsies will usually be refused for deceased relatives because of the fear the autopsy will preclude reincarnation or result in an incomplete reincarnated being.

Medications. In Laos, medicines were frequently shared between family members and this is still done in the US. Medications were discontinued when the person felt better and the notion of taking a medicine for a certain length of time, despite feeling healthy again, is an unfamiliar concept for the Hmong.

Patient-physician relations. To a large extent, Western medicine is very egocentric. Our way of doing things is seen as the "best" way or the only correct way. We are frequently uninterested in and intolerant of medical practices unfamiliar to us. Our expectation is that our patients will obediently accept and follow our advice and prescriptions exactly. A reluctant or resistant patient is regarded as stubborn, non-compliant, or ignorant. This may lead to the provider showing impatience or anger.

Provider-patient relationships with the Hmong are extremely delicate. Trust and confidence which has been gradually established can be destroyed with a single negative experience and result in a bad reputation for a doctor, a clinic, or a hospital. The story of one person's bad experience may spread throughout an entire clan and result in all clan members avoiding a particular doctor or hospital. Thus, every provider's actions and behavior can have major consequences and repercussions in the Hmong community. Taking time to explain and educate is very important.

Hmong patients may also be confused or insulted by our disinterest in their impression or opinion about their condition. Asking them what they think can help in developing rapport.

Clan influence. In addition to the provider's recommendations, the Hmong patient may seek advice and treatment from the shaman, the herbalist, the clan leader, or other family members. Health care providers need to realize that many people may be involved in and influence a patient's care. Accepting, and even welcoming, clan input can be very helpful.

Respect and a desire to please authority is part of the Hmong tradition. While the patient may seem accepting of the provider's recommendations, they may choose to act otherwise. Older physicians, especially males, tend to command more respect and may have more credibility and success, particularly in difficult situations.

Forecasting harm. When patients fail to comply, particularly in serious or life-threatening situations, providers may try to convince, pressure, or demonstrate the gravity of the problem by saying something such as, "If you don't do what I say, then....," followed by a description of a terrible outcome, even death. The Hmong believe that by making such a statement, the doctor is actually forecasting or projecting the bad outcome onto the patient and will therefore be responsible if it transpires.

An indirect, more positive approach is generally more successful (ie "If this medicine is taken regularly, you will feel better and live longer").

Preventive medicine. The concept and practice of preventive medicine is entirely new for the Hmong. Many do not understand the need for vaccines, cholesterol screening, and other prevention measures. For them, illness is not viewed in scientific terms, but rather as a spiritual or physical imbalance, disharmony, and a loss of soul. The Hmong often do not see value in getting medical care until they are sick, and sometimes actually delay seeking care until they are very ill. Requesting care from Western providers may also be postponed until traditional healing methods have been tried and have provided little or no improvement in the patient's condition.

Hmong patients present to Western medical providers seeking symptom relief, not necessarily for a diagnosis. Traditional Hmong healers are able to surmise a person's ailment without having to ask questions or even touch them directly. Hmong patients may therefore be suspicious of Western providers or doubt their competence when they need to ask detailed questions and perform a physical examination and laboratory tests to ascertain a patient's problem. Patients may also be offended by and unwilling to respond to personal or sensitive questions. Additionally, Hmong patients expect to receive medication to relieve their symptoms and may be upset or critical of their care when they don't.

Barriers to care for the Hmong such as inadequate access to providers, inability to speak English, and lack of transportation can also result in delays in receiving health care.

Many Hmong may not understand or adhere to our recommended health maintenance schedules. Hmong children may fall behind on their immunizations as a result. When a Hmong child comes for an appointment, the provider may want to administer several vaccines at one time to bring the child up to date.

Often, Hmong parents are hesitant or resistant to having their child receive more than one or two vaccines at one time. The current pediatric vaccination schedule calls for multiple vaccines to be given during the first 6 months of life. The Hmong parent may raise concerns that the baby is too young, too small, or not strong enough yet to be vaccinated and wish to postpone the shots until later. Compounding this problem is the 1990 CDC recommendation that infants and children of populations endemic for hepatitis B (which includes the Hmong) should be vaccinated with hepatitis B vaccine. This has increased the number of shots recommended for routine administration to Hmong children.

Bargaining and compromising. Bargaining or compromising may be necessary in many situations. In non-life-threatening cases, it may help to develop a rapport

Continued on page 648

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Continued from page 646
which will prove beneficial for future interactions. Opposing viewpoints in serious or life-threatening situations prove more difficult.

Hmong patients and their families may want to consult with clan or community members to help them reach a decision, or they may request a second opinion from another doctor. Depending on the urgency of the patient's problem, providers may find themselves in a difficult position.

Our society recognizes the right of persons who are felt to be of sound mind to refuse or ignore medical advice or interventions which are judged to be medically beneficial for them. An entirely different situation arises when it is perceived that a parent's wishes or beliefs are preventing a child from receiving necessary medical therapy. US providers are legally bound to report such cases to the appropriate authorities, and this has proved very problematic when dealing with the Hmong.

In our experience, Child Protective Service (CPS) has been very reluctant to get involved unless the case is truly emergent and life-threatening. CPS tends to be very conscious of the reverberations that antagonistic encounters can have in the Hmong community. Also, families who are pressured may choose to leave town or go underground. Providers are encouraged to use their best judgment while advocating for the child's health and safety.

Drawing blood. Drawing blood is another potential problem area when dealing with the Hmong. The Hmong believe that removing too much blood from the body drains it of valuable warmth and disrupts one's harmony. Discussing with the patients the reason for the blood testing and also assuring them that only a safe amount of blood will be withdrawn can alleviate some of their anxiety.

Translators. The use of translators is another sensitive issue. Any physician who has conducted a medical interview through a translator knows the frustration of not being able to directly communicate with the patient. Questions asked by the physician frequently lead to long discussions between the patient and the translator only to be relayed to you as a simple "yes" or "no" answer. A Hmong translator who is the employee of a clinic or hospital may be viewed by the Hmong community as being on the side of the physician and they may have difficulty appearing impartial and maintaining credibility in their community.

Many times, a trained Hmong translator is unavailable and a family member or friend is used. While one obviously needs to utilize whatever resource is available, the person translating may be unable to adequately translate medical issues. Younger persons and children are often the most proficient in English in a family and may have to translate for their parent or an elder. It is generally viewed as disrespectful for a younger person to translate for someone older and this should be avoided if possible. Children may also be limited in their ability to translate complex medical problems and their treatments. Using bilingual, bicultural, trained medical translators is obviously best.

Community organizations such as the Mutual Assistance Associations (Lao Family Community, Hmong American Friendship Association-Milwaukee) are active in many areas in Wisconsin and can provide translation and patient advocacy services.

Hmong modesty. Generally, the Hmong are extremely modest, and disrobing for a physical examination is an embarrassing and anxiety provoking experience. Hmong women are especially uncomfortable with male providers and male translators. Family planning, sexuality, and pregnancy and birth issues are examples of topics that may be difficult to effectively discuss. Taking measures to assure patients' modesty and attempting to have same-sex providers and translators is recommended.

The head as sacred. The head is considered by the Hmong to be sacred. It is believed to be the seat of life. Patting or touching a patient's head is viewed as disrespectful and should be avoided whenever possible. Intravenous lines placed in infant scalp veins are frightening to the Hmong as it might enable the infant's soul to leave his or her body. Frequently, hats are worn to prevent the soul from escaping.

Patient aids. In Western medical settings, it is common practice to employ handouts, brochures, and other reading materials for explanatory and educational purposes. Many Hmong people are unable to read English, and many may not read Hmong either. Hmong was strictly an oral language until a written version was developed in the 1950s. Patients who are literate must be able to comprehend the level of the materials provided.

Pictures, models, and illustrations may be useful in communicating information to Hmong patients. Efforts should be made to make these culturally relevant and fairly concrete. Even showing patients their X-rays or CAT scan may help the patients better understand their condition.

"Invisible" conditions. Internal or "invisible" ailments, particularly those with few or subtle physical manifestations, can be difficult for the Hmong patient to grasp. Blood abnormalities such as electrolyte imbalances, hypercholesterolemia, and anemia are new and perplexing concepts.

Lead poisoning is a striking illustration for the pediatric physicians. Lead screening programs have periodically identified Hmong children who have elevated lead levels. The severity of the lead problem for the Hmong in part parallels that of other inner-city children who live in dwellings that contain lead-based paint, which serves as the major source of lead. But some of the Hmong healing potions, especially the red powder, may contain lead and contribute to the elevated lead levels in Hmong children.

Children with elevated lead levels can appear relatively asymptomatic. Trying to explain the hazards of this invisible substance to Hmong parents can be quite challenging. Even more difficult is explaining the treatment for lead intoxication, which can range from doing nothing except cleaning up the lead hazards in

and around the home and following serial blood lead levels, to hospitalizing the child and giving chelating agents intravenously and via painful injections. With or without treatment, the child usually appears virtually the same to their parents and this adds to their confusion. Additional courses of chelation, when medically necessary, are frequently refused.

The hospital experience. As stated earlier, hospitalization can be a frightening experience for the Hmong patient and something they may try to avoid. Western hospitals, especially teaching institutions, can be quite bewildering. A variety of different medical personnel including doctors, residents, nurses, students, and others may examine the patient and deliver information. Efforts to identify one person who can be recognized by the patient and their family as "their doctor" will prove helpful.

As discussed earlier, personnel should also realize the significance of the string bracelet worn on the patient's wrist. This bracelet should not be removed to put on a hospital identification bracelet or to start an intravenous line.

Sometimes the family of a critically ill Hmong patient does not demonstrate the level of concern that Western society deems appropriate. This relates to the Hmong concept that the good of the clan and the family supersedes that of any one person. The family may not understand why we expend so much effort for one individual. Also, death for them is not final, but leads to reincarnation and the next life. Our practice of heroic interventions may seem senseless to them. Hmong culture values quality of life and living harmoniously as opposed to the Western goal of prolonging life at all costs. It is also preferred that a person be allowed to die at home rather than in the hospital.

The Hmong in America. Specifics of a patient's medical history are often difficult to ascertain. Diagnoses and dates of previous illnesses are often unknown or have not been recorded. Even a patient's stated age may be incorrect.

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A family history of a Hmong patient will many times reveal that one or more close family members have died, usually while still in Laos and often at a young age. A Western practitioner might think of familial or genetic disorders as a possible etiology for these deaths. But, when attempting to find out from the family the causes, the response is often "They died in the war," or "They became very sick and died," many times never reaching a doctor or hospital.

A pediatric examination may reveal a child of small size when their growth parameters are plotted against our standard growth curves. Applying our standard to a group of people with a different set of norms can prove misleading. It would be an obvious error to label a small but healthy Hmong child as a "failure to thrive." Using the growth chart to monitor a Hmong child's growth rate is more beneficial.

The Hmong perception of times is quite different from that of the Western world and they may not understand or comply with our demand for punctuality with appointment times.

Perinatal concerns. Labor and delivery in a US hospital can be an overwhelming and disconcerting experience for Hmong women. Modesty is widely disregarded and failure by the patient to understand or follow instructions can lead to difficulties. Hmong women may resist having their membranes ruptured, refuse to effectively push during contractions, and may not want a cesarean section regardless of the urgency of the situation. US obstetrical personnel are often quite impressed with the stoicism Hmong women display during childbearing.

The birth process is believed to drain the Hmong woman of vital body warmth. The family will usually bring the postpartum woman hot food and soups to

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replenish her body. After having a baby, Hmong women are traditionally allowed to recuperate for several weeks while someone else in the family does their work and cares for their baby.

Interestingly, the majority of Hmong newborns in the US are given infant formula instead of breast milk. The explanation for this is felt to be multi-factorial but it is certainly a major change from the universal practice of breast-feeding babies born in Southeast Asia. Colostrum is viewed as unhealthy by the Hmong and is usually expressed and discarded by those Hmong women who chose to breast-feed. Traditionally, Hmong newborns are fed by a nursemaid until their own mother's breast milk comes in and the production of colostrum has ceased.

Birth control was not practiced by the Hmong in Laos, and explaining its purpose and techniques can be quite challenging for medical personnel.

Hmong diseases. While recommendations and discussions of the evaluation of the health status of Southeast Asian patients have been delineated in other articles, mentioning certain entities will hopefully prove helpful. Hepatitis B and tuberculosis are endemic in the Hmong. Parasites may be present, especially in those who have recently arrived from Southeast Asia. Malaria may be a consideration. Abnormal blood values and indices may point to an anemia or hemoglobinopathy. Poor dentition is common.

Mental illnesses such as depression and post-traumatic stress syndrome are prevalent. Mentally ill patients are viewed as a source of shame for the family or the clan. Patients and families may try to minimize or deny evidence of mental problems. Emotional problems may be presented as somatic complaints.

Sudden unexplained nocturnal death syndrome (SUDS) is a frightening phenomena, the etiology of which is unknown and has taken the lives of seemingly healthy Hmong male immigrants.

Hope for the future

Despite coming to America under extreme duress, the Hmong people, in general, have adapted to life here quickly. The strong Hmong work ethic, their intact family units, and the close-knit community have provided a solid foundation for them during their transition. Many Hmong have successfully found employment and are learning English.

Hmong children are generally doing well academically. Several of the recent valedictorians of Milwaukee city high schools have been Southeast Asians.

A study conducted for the Wisconsin Policy Research Institute showed that between 1988 and 1990, the percentage of Hmong on welfare declined 19%, and that Hmong children registered grades 40% higher than native Wisconsin students, and graduated at rates near 100%. An increasing number of graduates are enrolled in colleges and vocational schools.

Hmong folklore, folk art, and food dishes are colorful new additions to American culture.

The Hmong will undoubtedly be making many positive contributions to American society in the years to come.

Recommendations. In conclusion, the following suggestions are offered to US medical personnel caring for the Hmong:

- be open to and accepting of the Hmong people and their ways;
- be patient and remain calm during patient encounters;
- demonstrate concern for the patient and his or her family;
- respect modesty;
- attempt to use same sex providers and translators;
- avoid using children as translators when possible;
- for the hospitalized patient, identify the medical person in charge;
- use culturally appropriate and concrete examples;
- recognize the role, involvement, opinions, and concerns of the patient, his or her family, and clan;
- compromise when necessary and appropriate;
- don't mistake culturally acceptable dermabrasive markings for evidence of child abuse;
- approach each patient individually–guard against assumptions and stereotypes;
- get help–use community resources where available.

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Three SMS members elected to WIPRO Board

As the result of a recent election, three SMS members have been elected to serve as new members of the Wisconsin Peer Review Organization (WIPRO) board of directors. At the WIPRO annual meeting, held Sept 22, newly elected board members began their three-year terms. Of the six seats available, two were non-physician seats, with one seat representing the interests of the insurance industry and the other seat designated to the public sector. Of the four remaining seats, three of the newly elected WIPRO board members belong to the SMS.

The following is a list of the new members:

- Southwest region–James E. Glasser, MD, an internist from La Crosse (SMS member), and Charles E. Link, MD, an internist from La Crosse (SMS member);
- Southeast region–Mark B. Adams, MD, a transplant and general surgeon from Milwaukee;
- Northeast region–Donald H. McDonald, MD, a family physician from Winneconne (SMS member);
- Insurance industry representative–Maurice Kiley, of Madison; and
- Public sector representative–the Rev John R. Johanssen, of Menomonie.

"I am pleased to see SMS members taking an active role in the all-important peer review process," said SMS President William J. Listwan, MD. "On behalf on the SMS, I would like to congratulate these individuals on their election."[150th]

Questions?
Call the SMS
1-800-362-9080.

A busload of volunteers left SMS headquarters under cloudy skies Sept 14, but by the time the bus arrived at the Fort Crawford Medical Museum in Prairie du Chien, the precipitation had begun to reach measurable levels. Fortunately, the wide verandas of the medical museum sheltered volunteers from the alternating rain and drizzle, allowing them to work in relative comfort. The hardy crews scraped, washed and painted windows, screens and exterior trim on the museum's expansive porch, preparing the museum for cold weather elements. The more experienced painters took on the job of power spraying the steel walls of Stovall Hall while other team members painted pillars, underhangs and finished working on the windows. A second smaller group returned to the museum Oct 7 to finish priming. A third expedition is being planned for the spring. According to SMS Executive Vice President Thomas L. Adams, CAE, the SMS volunteers saved the museum more than $2,000.[150th]

Physician-Citizen of the Year nomination letter

Two years ago, the SMS opened to the public the nomination process for its Physician-Citizen of the Year award. The result was an overwhelming outpouring of admiration and affection for Wisconsin's physicians. Some, like the note below, are elegant in their innocence and simplicity. As a service to the members of the SMS, the *WMJ* is sharing some of these nominating letters with its readers.

The letters are edited only for length and the removal of personal names. The letters reprinted are not necessarily the nominations of the winning physicians.

I love my doctor. When I enter his office a big hand shake and a big smile.
I feel comfortable then.
He don't use words we old people don't understand.
He take time with you.
I am 87 years old and he respects old people.
He is the doctor of the year.[150th]

The march of medicine: H. Kent Tenney, MD

LeeAnn Kahlor, SMS student intern

H Kent Tenney, MD, was the kind of doctor of which most patients can only dream–he saw thousands in one day, answered all their questions, and never sent them a bill. All it took was his own radio show.

Via the educational radio network, listeners across the state tuned in once a week to get friendly medical advice and some warmth and wit from their favorite physician on "The March of Medicine" broadcast. The show was such a marked success it ran for 16 years and even received air time on a Navajo Indian reservation in New Mexico–translated into Navajo (Dr Tenney was an Ottawa descendent). Known for his ability to explain the most complicated of medical topics to a non-medical audience, Dr Tenney's motto was "If you can't say something medical in words any layman can understand, then I don't think that you really understand it yourself."

Although Dr Tenney's radio show was only a fragment of his accomplished career, it represented one of his most notable contributions to medicine: opening the lines of communication between physicians and their patients. A report done on the show in the mid-1970s revealed that a sizeable portion of the listener mail alluded to a lack of communication with personal physicians. Letters stating, "My own doctor is very busy and hard to talk to..." and "(I receive) evasive answers from my doctor," prompted Tenney to write to the University of Wisconsin Medical Center, "Let (the faculty) know how important it is to train the younger physicians to take plenty of time in discussing all aspects of a case with a patient."

Throughout his career, Dr Tenney strove to maintain frank and open relationships with his patients and students. A graduate of Northwestern Medical School, Dr Tenney arrived in Madison in 1920 as a member of the Student Health Service of the University of Wisconsin. His association with the medical school continued for many years in the department of pediatrics and eventually lead to being named emeritus professor in 1965. Having established one of the first pediatric practices in Madison, Dr Tenney once said, "When I came to Madison there were only four of us; now, I don't even know

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Continued from preceding page
all the pediatricians in the city." More than likely, they knew of him.

Dr Tenney's career as a pediatrician and child psychologist was a long, illustrious one (he practiced until the age of 83). Primarily interested in the psychological well-being of children, Dr Tenney was often identified with activities for the betterment of child health. In 1934 he responded to parents' complaints that doctors were giving inconsistent advice on child rearing, by writing a lighthearted but helpful book titled, "Let's Talk About Your Baby." Written in Dr Tenney's characteristic sympathetic and understandable language, the book was well received and subsequently published in three editions.

Aside from writing, Dr Tenney lectured regularly for various organizations and associations throughout the state about children's need for emotional stability and familial support, a subject which until then had been largely ignored. One of Dr Tenney's speeches to a women's club in the early 1960s began, "Give your child a feeling of trust in the world around him, and help him gain a feeling he has a position in life." He also hosted a radio show titled, "Ask Dr. Tenney," which was geared toward grade school children and distributed for a program titled "School of the Air."

He was an innovator and served as a prime developer of Wisconsin's well baby clinics, which were designed to counsel legions of parents on the importance of good nutrition and child care.

Other accomplishments that led Dr Tenney into prominence within the medical community included: chair of the Governor's Conference on Children and Youth in 1953; state chair of the American Academy of Pediatrics; president of the Dane County Medical Society; speaker of the SMS House of Delegates; "Man of the Year" recognition by the Wisconsin Association of Mental Health; and president of the SMS.

After a 1965 conference in conjunction with the American Medical Association, a public relations specialist for the SMS commented, "If there were 50 Dr Tenneys in the state, who practiced medicine and lived the way he does, there would be no need for a medical public relations program."

When Tenney passed away in 1982 he left behind a legacy of good humor and humanitarian concern for all of professional medicine to emulate, best exemplified by his signature sign-off for his radio program: "So long folks. Now take good care of yourself and have fun."[15,0th]

A glimpse into our past

Richard Sautter, MD, medical editor

12 years ago

The unimpaired physician. SMS President Darold Treffert, MD, urged Wisconsin's medical community to "mellow" for their own sakes. He echoed his patients' definition of a meaningful life as a sort of prescription: "It should have some warm, human relationship. It should have in it the opportunity for self-expression and honesty without penalty. It should have a sense of structure and hope for the future. It should provide a person with a sense of belonging to something larger than himself that is worthwhile. It should be a life that the individual feels he has made through his own efforts....

"That's Mellowing," wrote Dr Treffert. "That's what will keep us unimpaired." That's also a paragraph worth reading more than once. Good advice from a good man.

24 years ago

No comment. The SMS Commission on Governmental Affairs endorsed an AMA House of Delegates position calling for the decriminalization of possession of marijuana. "It is our belief" wrote the commission chair, "that a person should nor be subject to arrest, imprisonment, and a criminal record for simple possession of small amounts. Criminal penalties are far out of proportion to the individual or social harm that may come from the offense." Say what?

36 years ago

A sign of times past. The SMS legal counsel received an inquiry as to whether it was lawful to perform a non-therapeutic vasectomy on the husband of a woman who, for her health, should not have more children but was unable to withstand a surgical procedure. The response was that "Sterilization is tolerated by the law only if it benefits the health of the patient on whom the surgery is performed." Family planning has come a long way since then.

48 years ago

And what a life it was. Kate Pelham Newcomb, of Woodruff, was featured on the television show "This is Your Life." Dr Newcomb had begun a fund drive to build a community hospital, but the drive fell $32,000 short (see a related story in the April 1992 *WMJ*). Dr Newcomb traveled to Los Angeles under the impression she was representing the SMS at a medical meeting, and members of her community flew west a day later. Her appearance on the popular program brought in 298 pouches of mail containing donations of

more than $75,000. Dr Newcomb was not only a pioneer among women physicians, she serves as a shining reminder that each of us can make a difference.

60 years ago
Sunbathing by prescription. The SMS Educational Committee issued an advisory for mothers to "put babies in the sun to insure robust health." The advisory was intended to ward off rickets. "Every mother who wishes her baby to have robust health should give him regular sun baths from early infancy until he is old enough to play in the sun himself.... The sun's rays ... must fall directly on the skin and tan it." Ironically, we're now trying to keep the sun worshipers and agricultural workers from getting too much sun and risking skin cancers.

72 years ago
The need remains. When a Milwaukee physician entered the Republican primary race for governor, the SMS offered this non-endorsement: "The *Journal* does not interfere in politics, but Dr Seaman is not a politician.... (But) if each (physician) will approach his friends before the primary and tell them what he knows of Dr Seaman, there can be no doubt of the outcome. Dr Seaman lost to John Blaine, who went on to serve as governor through 1927. The portion of the endorsement that rings true today read, "Never has there been so great a need of active, trained physicians in public life. For years, we have been approaching conditions which thoughtful people have viewed with alarm...."

84 years ago
A meaty issue. With the support of the SMS, and over the mayor's veto, Milwaukee passed an ordinance to regulate food stores. Included in the law was a prohibition of "the exposure of carcasses of animals in front of shops" and a requirement for the "proper labeling of all dog and horse meat or sausage containing such." The public health measure was predicted to lower the city's mortality rate. Also a break for dogs and horses.

96 years ago
If we'd known then what we know now. Observing that the "habit of cigarette smoking is constantly increasing among the boys," Dr Selena Severson wrote in the *WMJ* that "Something should be done to stop it." Dr Severson wrote that although "it cannot be said to cause directly any organic disease of the lungs," smoking thinned the blood, lessened the body's vigor and made boys less able to withstand disease. Other effects included discoloration of the teeth (although the "free carbon deposits" from smoking were thought to act as an antiseptic and preservative); contraction of the intestines, resulting in constipation; reductions in "gastric juice," resulting in "dyspepsia and loss of appetite"; heart palpitations and pain; paralysis of various nerves, resulting in a range of symptoms from "obscurity of vision" to "death from respiratory failure ... or paralysis of the heart."

Overall, smoking was thought to overwork the lungs, skin and kidneys in ridding the body of inhaled poisons, resulting in "Impairment of growth, premature manhood and physical degradation." What exactly is premature manhood? 150th

Physician briefs

The * indicates SMS membership.

Martin Arnold, MD,* has joined the staff of Green County Anesthesiologists and St Clare Hospital in Monroe. Dr Arnold earned his medical degree from the University of Nebraska College of Medicine-Omaha in 1988. He interned at Presbyterian Medical Center and completed a residency at Temple University Hospital, both in Philadephia.

Artuto Camacho, MD, a neurosurgeon, has joined Marshfield Clinic, after practicing in Dubuque, Iowa. Dr Camacho served his residency in neurosurgery at Mayo Clinic in Rochester, and earned his medical degree from the University of Illinois in Chicago.

Jeffrey J. Huhn, MD, has entered practice with John Herlache, MD, in Sturgeon Bay. A graduate of the U.S. Coast Guard Academy, Dr Huhn graduated from the University of Wisconsin Medical School in 1987. He completed his general surgery residency at Marshfield Clinic in June.

Wahab Kazi, MD,* a family physician, is now practicing at the Lake Mills Medical Center. Dr Kazi graduated from medical school at AinShams University in Cairo, Egypt. He completed internships in Egypt; Bombay, India; and at the Medical College of Wisconsin. His residency was spent at St Catherine's Hospital in Kenosha.

Michael B. Liebe, MD,* has joined the Family Practice Clinic of Sparta as a family practice physician. He earned his medical degree from the University of Minnesota and completed his residency with the St Francis-Mayo residency program in La Crosse.

Jerry Miller, MD,* has joined the Dells Clinic in Wisconsin Dells and the Medical Staff at St Clare Hospital. A family physician, Dr Miller earned his medical degree at Centro De Estudios Universitarios

Continued on next page

Xochicalco in Mexico in 1988 and completed a 5th year of medical training at the University of California, Irvine. He completed a 3-year family practice residency at St Luke's Hospital in Milwaukee in June.

James E. Mullen, MD, is a new addition to the staff of Howard Young Medical Center. Dr Mullen earned his medical degree at the University of Wisconsin-Madison, interned at State University Hospitals of New York, and completed a residency in physical medicine and rehabilitation at Buffalo.

Howard Palay, MD,* of Allouez, was among 13 community leaders recognized recently by the Jewish National Fund, an apolitical group responsible for afforestation and land reclamation in Israel since 1901. A cardiologist, Dr Oakay founded the Green Bay Paramedic Program and serves as president of the American Heart Association of Wisconsin. He was named Wisconsin Outstanding Physician by the AHA and also has been recipient of the state and county AHA service awards.

Judith Pauwels, MD,* is now affiliated with River Valley Medical Center and St Croix Valley Medical Center in St Croix Falls. A family physician, Dr Pauwels previously practiced medicine in Waukesha.

Richard Pebler, MD, a family physician, has relocated to Wisconsin from Colorado, where he was in private practice. Dr Pebler earned his medical degree from the University of Massachusetts. He now resides in Rice Lake and practices at the Marshfield Clinic-Indianhead Center.

Steven Savage, MD, of Appleton, is a new member of the Calumet Medical Center. Dr Savage is board certified in obstetrics and gynecology. He received his medical degree from the Medical College of Wisconsin and did his residency at the Medical College of Ohio at Toledo. Dr Savage practices with OB/GYN Associates, of Appleton.

Mansoor Shariff, MD, has joined Internal Medicine Associates of Manitowoc-Two Rivers. Shariff earned his medical degree from the University of Wisconsin Medical School. He performed a fellowship in gastroenterology at the University of Missouri Hospitals and Clinic.

Steven D. Stenzel, MD,* a gynecologist, is a new member of the medical staff at Bloomer Community Hospital. Dr Stenzel earned his medical degree from the University of Iowa. He is board certified in gynecology and formerly practiced with the Midelfort Clinic in Eau Claire.

Michelle Storms-Van Howe, MD,* joins the staff of Marshfield Clinic-Lakeland Center. She earned her medical degree at St Louis University School of Medicine in Missouri, and served her residency in family practice at St Mary's Hospital in Milwaukee.

William Sullivan, MD,* has been named medical director of the adult outpatient unit of Parkside Lodge in Wisconsin. A 1974 graduate of the Medical College of Wisconsin, Dr Sullivan completed his residency at Setterman Army Medical Center in San Francisco. He currently is medical director at the psychiatric unit at Mercy Hospital in Janesville and a consultant with Beloit Memorial Hospital. He is board certified in both psychiatry and neurology.

Sridhar V. Vasudevan, MD,* was the invited plenary speaker at the 5th International Congress held September 14-18 in Jerusalem, Israel. He spoke on "Rehabilitation Principles in Managing the Patient with Chronic Pain" at the meeting sponsored by the World Society of Pain Clinicians and the Israel Pain Association. Dr Vasudevan is the medical director of the Pain Rehabilitation Center at Elmbrook Memorial Hospital and medical director of the Center for Pain and Work Rehabilitation at St Nicholas Hospital in Sheboygan.[150th]

AMA awards

The Wisconsin physicians listed below recently earned AMA Physician's Recognition Awards. They have distinguished themselves and their profession by their commitment to continuing education, and the SMS offers them its congratulations. The * indicates members of the SMS.

September 1992

Belgado, Paulino G.
* Boehm, Frederick J.
De Kraay, Warren H.
* Fletcher, Fred W.
* Galarnyk, Ihor A.
* Kidder, Thomas M.
* Knoch, Frederick W.
* Laufenburg, Herbert F.
Liedtke, Arthur J.
Mc Ginnis, Kathleen J.
* Merlis, Anthony L.
* Plautz, Arthur C.
* Tiffany, Joseph C.
* Wenman, Michael S.
* Zimmers, Herbert J.[150th]

SMS news posters mailed to Wisconsin hospitals

The SMS has mailed out the premiere edition of its news poster, *Medical Times*, to all Wisconsin hospitals. The 11" by 17" poster will be displayed in hospital medical staff lounges, providing physicians with a fresh look at medical, socioeconomic and organizational news. The news poster will be printed on a monthly basis. If you don't see the black and white poster displayed at your hospital, contact *Medical Times* Editor Shari Hamilton at the SMS (1-800-362-9080).[150th]

County society news

Outagamie. David W. Duppler, MD, has been accepted to membership in the Outagamie County Medical Society.

Price-Taylor. Members accepted to the Price-Taylor County Medical Society are: Everin Houkom, MD; Frank Waites, MD; Pete Dahlie, MD; and Joe Boero, MD.

Racine. The Racine County Medical Society accepted the following members at their September meeting: Edgar D. Dizon, MD; Jerome D. Fallon, MD; Mark A. Klaas, MD; John A. Martini, MD; Nagendram Paidisetty, MD; and Ranga R. Sriram, MD. Dr Richard Minton has been accepted as a retired member.

Vernon. Featured speakers at the Vernon County Medical Society September meeting were Sen Brian Rude and Dr Duane Koons. Health care and legislative issues were discussed. Members interested in attending the next meeting should contact Dr Mark Andrew.

Winnebago. Thirty members were present at the October meeting of the Winnebago County Medical Society. Accepted into membership were Patrick Obrein, MD; Robert McDonald, MD; Albert Wankel, MD; David Burch, MD; Thomas Tolly, MD; Patricia Kasper, MD; Teresa Shoberg, MD; William Kasper, MD; Jeanettie Salone, MD; Tiffany Corrigan, MD; Sangita Patel, MD; and Robert Bernstein, MD. Prior to the start of the formal business meeting, Rep David Prosser and Sen Carol Buettner discussed the current state legisative process.[150th]

SMS annual meeting
April 15-17
La Crosse, WI

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Obituaries

William T. Brodhead, MD, a lifelong resident of Madison, died July 30, 1992, in Door County. He was born on February 1, 1927 and graduated from the University of Wisconsin Medical School in 1953. He served his internship in Portland, Ore. Dr Brodhead served in the US Air Force and was a member of the Dean Clinic Medical Center, starting its orthopedic department in 1961. He was a member of the Academy of Orthopedic Surgeons, American College of Surgeons, Mid-America Orthopedic Society, Wisconsin State Orthopedic Society, the Dane County Medical Society, the SMS and the AMA. He served as associate professor at the UW Medical School for many years. Surviving are his widow, Janet; three children, Leslie Griffith of Madison, Elizabeth Brodhead of Madison, and Thomas Brodhead of Salem, Ore; a granddaughter, Julia Griffith; a sister, Gail Stebbins of LaConner, Wash; and two brothers, Richard H. Brodhead, MD, of Hot Springs Village, Ark, and David Brodhead, of New York.

Wylie Dodds, MD, of Brookfield, died Aug 2, 1992. Dr Dodds earned a medical degree from the Cornell University School of Medicine in 1960. He was a professor of radiology at the Medical College of Wisconsin for 23 years. In addition to his development of research and education programs, he was a practicing radiologist at the Milwaukee County Medical Complex and Froedtert Memorial Lutheran Hospital. In 1990, he was awarded the Walter Cannon Award of the Society of Gastrointestinal Radiologists and the Distinguished Service Award of the Medical College of Wisconsin. He was also named as visiting lecturer for the Society of Gastrointestinal Radiologists in 1986. Surviving are his wife, Carolyn, and three children, Jennifer, Stuart and Elizabeth.

Ely Epstein, MD, of Milwaukee, died Sept 5, 1992. He was 85 years old. Dr Epstein, a pediatrician, practiced in Milwaukee for more than half a century. He was a pediatrician at Children's Hospital of Wisconsin from the mid-1930s until he retired in the late 1980s. He was the hospital's chief of pediatrics for several years. He also taught at Marquette Medical School for about 50 years. Surviving is his widow, Marianne; two daughters, Ellen Zetcher of Boston and Anne Epstein of Ann Arbor; and two sons, Eric Epstein of Norwalk and David Epstein of Milwaukee.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.

Mark Anthony Foster, MD, formerly of Madison, died Sept 3, 1992 in Blue Mounds. Dr Foster was born in Ashland, Lou, Oct 15, 1906. He received his medical degree from Harvard in 1937. He was selected for inclusion in American Men of Science and became a fellow of the Mayo Clinic in the field of internal medicine. He served in the US Naval Medical Corps at the Bethesda Naval Hospital and at Port Said, Egypt. Upon returning to the United States, he served at the Great Lakes Naval Hospital until he was discharged from the Navy with rank of lieutenant commander. Dr Foster practiced internal medicine at the Mayo Clinic for more than a year before entering private practice in Madison. Dr Foster was preceded in death by his wife, Dr Ruth Caldwell Foster, his parents, and his sister, Christian. He is survived by his sister, Myrta Graham of Ashland, Lou; son James of Winona, Minn; son Mark, Jr, of Black Earth; son Thomas, of Blue Mounds; and nine grandchildren.

Ruth C. Foster, MD, of Blue Mounds, died Aug 11, 1992. Dr Foster was born Aug 17, 1904 in Ridgeland and graduated from the first class of the University of Wisconsin Medical School in 1929. She interned at Chequamegon County Hospital and completed her residency in internal medicine at the American College of Physicians in Flint, Mich. She received a faculty position and later, promotion and tenure in the University of Wisconsin Medical School. For many years, she presided over the university's student health program. She and her husband were in private practice together with her brother-in-law for 40 years. She was lauded by the SMS for 50 years of continuous service as a physician. Her husband, Dr Mark A. Foster, died Sept 3, 1992. She is survived by three sons, James, of Winona, Minn; Mark, Jr, of Black Earth; Thomas, of Blue Mounds; and nine grandchildren.

Clement Thomas Ziegler, MD, of Whitefish Bay, died Aug 11, 1992, in Milwaukee. He was 75. He was one of the founding physicians of Northpoint Medical Group and a member of the AMA. He graduated from Marquette Medical School in 1942, served his internship at St Mary's Hospital, and was a member of the medical staff until his death. A veteran of World War II, he was awarded the Silver Star for heroic action under fire. Dr Ziegler is survived by his wife, Elizabeth; two daughters, Kathleen Kay and Mary Beth (Hampton) Waring; son Mark Ziegler; four grandchildren, two brothers, and a sister.

University of Minnesota— Medical Director Position. Boynton Health Service, a large multi-specialty outpatient facility affiliated with University of Minnesota Hospital and Clinic, is seeking a Medical Director. This position is responsible for coordinating and supervising all medical services to 50,000 students, faculty, and staff. This academic professional appointment requires an MD/DO degree, BC.BE in a primary-care specialty, and eligible for Minnesota licensure. The successful candidate must relate well to an educated, health consious, and international clientele of students faculty and staff. Responsibilities will include administrative and clinical duties (equally divided), in a managed care environment. Salary commensurate with training and experience. Outstanding benefits include a generous academic-status benefit package plus teaching opportunities. Review of applications will begin on November 15, 1992, and will continue until the position is filled. Boynton Health Service, Attention: Michael Coomes, MD, Search Committee, 410 Church Street SE, Minneapolis, Minnesota 55455 – (612) 624-2933. The University of Minnesota is an equal opportunity educator and employer. 11/92

Milwaukee area. A rapidly expanding 68 physician multi-specialty clinic seeks BC/BE physicians in the following specialities: family practice, internal medicine, ob/gyn, urology, psychiatry, oncology, and pediatrics. Competitive salary, excellent fringe benefits. Address inquires and CV to: Medical Associates Administrator, PO Box 427, Menomonee Falls, WI 53052-0427. 11-12/92-1/93

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Family Practitioner to associate with a 3 physician group (1 semi retired). Rural family health center with an excellent support staff and unlimited potential. Complete fee-for-service practice with excellent hospitals and specialty support only minutes away. Guaranteed salary, incentives and benefits tailored to fit your needs. Located 15 minutes from Green Bay and 30 minutes from Door County vacation area. Interested physicians please contact: Shirley Nell, Office Mgr, Luxemburg Medical Clinic, Box C, Luxemburg, WI 54217. 11-12/92

Opening - Family practice. Location: one hour from Twin Cities. Call: one in seven. Group size: six physicians. Salary: $100,000. Signing bonus: $20,000. Loan forgiveness: $50,000/five years. Lake living: choice of two adjacent to our community. Contact: call collect 612/796-6220 (8 am to 10 pm). Also available openings in general surgery, orthopedic surgery, and OB/GYN within one hour of Twin Cities. Excellent compensation packages available with bonuses and loan forgiveness programs. 11-12/92

Family practice. Physicians seeking a BE/BC family practice physician for Norway, Michigan. Physician could join the existing practices or setup his own. Anderson Memorial Hospital is part of Dickinson County Hospitals with a service area population of over 60,000. Salary guarantee of $125,000 with excellent benefits. Contact: Dr. Paul Hayes (906) 563-9255, Dr. William Gladstone (906) 563-8743 or John Schon, Administrator (800-236-3240), Anderson Memorial Hospital, Main Street, Norway, Michigan 49870. 11/92

Ideal internal medicine practice. Excellent opportunity for BC/BE internist to establish a prosperous practice. Progressive 107-bed community hospital with a medical staff of 48 physicians and a service area population of over 60,000. Vibrant Northern Michigan community with all summer and winter recreational activities. Salary guarantee of $135,000 with excellent benefits. Send CV or contact: John Schon, Administrator, Dickinson County Hospitals, 400 Woodward Avenue, Iron Mountain, Michigan 49801, (800) 236-3240. 11/92

Internal medicine. Large, multispecialty group in the Minneapolis/St. Paul area seeks additional BE/BC general internists. Busy, established primary care practice with focus on ambulatory geriatrics; competitive guaranteed base salary and full benefit package; no practice buy-in. Send vitae to or call: Nancy Borgstrom, Aspen Medical Group, 1020 Bandana Boulevard West, St. Paul, MN 55108, 612-641-7170. EOE. 11-12/92-1/93

Urgent care. Marshfield Clinic is seeking several additional physicians trained and certified in primary care (including family practice, internal medicine, or pediatrics) to join its expanding Urgent Care practice section. As a 400-physician multispecialty group, Marshfield Clinic is at the forefront of today's medical practice. You would be joining top professionals committed to advancing health care services while enjoying full on-site medical and surgical support of one of the nation's premier groups. If you would like to practice in a state-of-the-art health care environment, and if you enjoy a life-style that's rich with recreational diversity, and if you would like to call "one of the best small cities in the midwest" home, contact: John P. Folz, Assistant Director, Marshfield Clinic, 1000 North Oak Avenue, Marshfield, WI 54449 or call collect at (715) 387-5181. 11-12/92

OB/GYN. Physician needed to practice obstetrics in a Northern Michigan community. Presently there are two OB/GYN's in partnership and an additional physician is needed. Partnership offers a salary guarantee of $225,000 with excellent benefits. Contact Doctors Cook or Henke at 906-779-1290 or John Schon, Administrator, Dickinson County Medical Hospital, 400 Woodward Avenue, Iron Mountain, Michigan 49801. (800-236-3240). 11/92

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Physicians Exchange

Continued

Orthopedic surgeon. Physician needed to practice general orthopedics in a Northern Michigan community. The partnership or solo practice offers a salary guarantee of $250,000 and excellent benefits. Contact Doctors Roberts or Slajus at 906-774-7647 or John Schon, Administrator, Dickinson County Memorial Hospital, 400 Woodward Avenue, Iron Mountain, Michigan 49801. (800-236-3240). 11/92

Gastroenterologist, neurologist, psychiatrist. Excellent opportunity for physicians to establish a prosperous practice at a progressive 107-bed community hospital with a medical staff of 48 physicians and a service area population of over 60,000. Vibrant Northern Michigan community offers all summer and winter recreational activities. Salary guarantees with excellent benefits provided. Send CV or contact John Schon, Administrator, Dickinson County Memorial Hospital, 400 Woodward Avenue, Iron Mountain, Michigan 49801. (800-236-3240). 11/92

Oshkosh, Wisconsin. Medical groups are recruiting in Internal Medicine, Pulmonology, Rheumatology, Emergency Medicine, OB/GYN, Child Neurology, Child Psychiatry, Ophthalmology, and Urgent Care. Mercy Medical Center has an active medical staff of 110 physicians in all medical specialties. Oshkosh is an attractive community of 55,000 people, located on the shores of Lake Winnebago and in the heart of Wisconsin's beautiful Fox River Valley (metro area of 400,000 people). University of 12,000 students. Competitive financial packages. Contact Christopher Kashnig, Mercy Medical Center, 631 Hazel Street, Oshkosh, WI 54902. Call 414-236-2430 or 800-242-5650, extension 2430. Fax: 414-231-5677. 10-12/92

Family Practice opportunities in Wisconsin, Illinois, New York, Michigan and Arizona. Urban, suburban, rural, solo, single specialty and multispecialty groups. All offer attractive compensation packages, with competitive salaries, benefits, income guarantees. For more detailed information about each of these practice opportunities, contact Carol Radke at 800-969-7715 or fax CV to 414-226-4131. All inquiries will be kept strictly confidential. 10-12/92

Family Practice Physician Board Certified - Board eligible to join 25 physician multispecialty group in Winona, Minnesota with existing four physician Family Practice Department. Total draw of 40,000 population. Competitive salary offered. Interested physicians please contact: J. B. Knuesel, Administrator, Winona Clinic, Ltd., 420 East Sarnia, Winona, MN 55987. 10-12/92

Staff psychiatrist. Medium-size smoke-free environment medical center offers primary and extended care to a large area of west central Wisconsin. Full range of psychiatric services include admissions (acute), geriatric, long-term care, out-patient, PTSD, and alcohol. Salary range to $119,500, depending on qualifications and board certification. Excellent benefits package includes malpractice protection, 30 days paid vacation, and annuity plan. Relocation expenses. 173-acre facility includes limited on-station housing and nine hole golf course. City of 7500 in a predominantly rural area that offers affordable real estate, good schools. conveniently located on I-90/94 midway between Milwaukee and Minneapolis. Call or write: Eugene J. Traynor, MD, Chief, Psychiatry Services (116A), VA Medical Center, 500 East Veterans St, Tomah, WI 54660; ph 1-800-252-7188. EO/AAE. 5-12/92

Family practice - Internal medicine to join seven BC family practice physicians and one BC general surgeon in beautiful northern Wisconsin. Clinic facility is attached to hospital and new nursing home. Resort area. If your family life and life style are important to you, this is the opportunity. Contact Stephen Carlson, MD, or Jeanne Chamberlain, Adm, Northwest Medical Center, 707 Ash Street, Spooner, WI 54801; ph 715-635-2151. 7-12/92

Part time/full time. Physician with an interest in geriatrics wanted to practice in a nursing home and out-patient (office) setting. No hospital work necessary. Flexible schedule. Send CV to or call G. D. Trepanier, MD, 481 E. Division Street, Fond du Lac, WI 54935. 414-922-1900 (office) or 414-921-3234 (home). 8-11/92

Family practice physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD, MBA, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 10-12/92

Wisconsin. Family practitioner needed by a growing practice of a four physician group in a friendly rural community in northeast Wisconsin near Green Bay. This is an excellent opportunity to join an established organization. Highly competitive salary with benefits. Please contact: Artwich Clinic, Oconto Falls, WI 54154. p7-12/92

RADIOLOGISTS

DVI Health Services Corporation, a publicly traded company on the New York Stock Exchange, has opportunities for radiologists in out-patient diagnostic facilities in various states. Immediate openings are available in Wausau, Wisconsin for individuals with extensive MRI experience and credentials. Send resumes to Cynthia Cohn, DVI Health Services Corporation, One Park Plaza, Suite 800, Irvine, CA 92714 or call (714) 474-5800. Compensation commensurate with experience. 11/92

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Medical Meetings-Continuing Medical Education

January 14-15, 1993. Nephrology Update Conference, Rapid City, SD, Contact Pat Sivesind 605/339-6790. 11-12/92-1/93

AMA

December 6-9, 1992: Interim House of Delegates, Nashville.
June 13-17, 1993: Annual AMA House of Delegates, Chicago.
December 5-8, 1993: Interim House of Delegates, New Orleans.
June 12-16, 1994: Annual AMA House of Delegates, Chicago.
December 4-7, 1994: Interim House of Delegates, Honolulu.

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 55 cents per word, with a minimum charge of $25.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg,* copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

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State Medical Society of Wisconsin

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1993-1994

The 1993 meeting will be in La Crosse. All other meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1993 - April 15-17: La Crosse Convention Center, Radisson
1994 - April 14-16: Milwaukee

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

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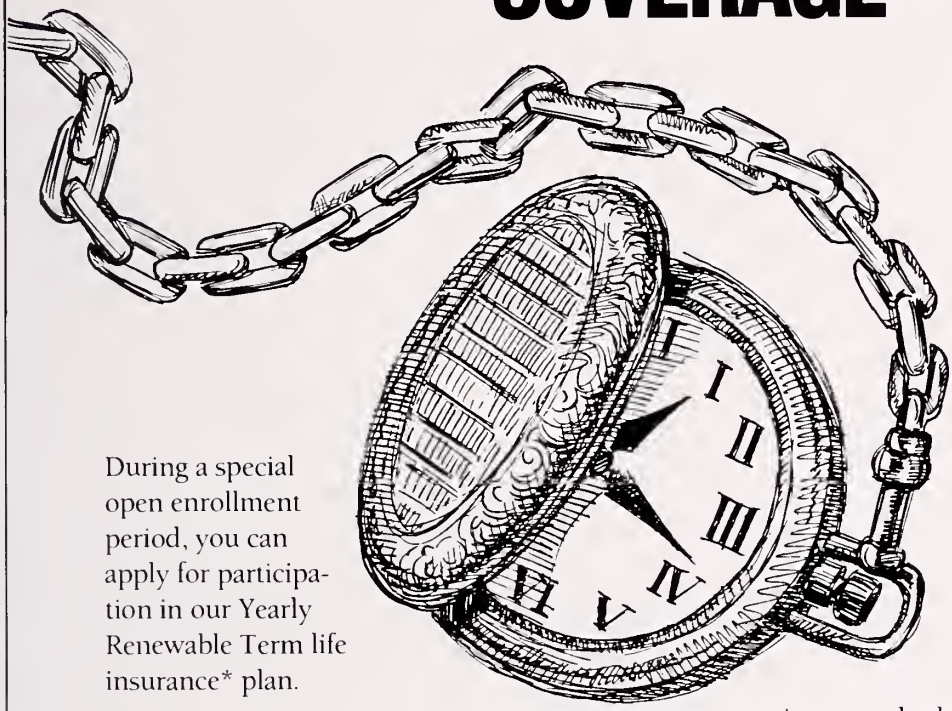

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†Constipation, which is easily managed in most patients, is the most commonly reported side effect of Calan SR.

‡Verapamil should be administered cautiously to patients with impaired renal function.

References: 1. Data on file, Searle. 2. Edmonds D, Würth JP, Baumgart P, et al. Twenty-four-hour monitoring of blood pressure during calcium antagonist therapy. In: Fleckenstein A, Laragh SH, eds. *Hypertension—the Next Decade: Verapamil in Focus*. New York, NY: Churchill Livingstone; 1987:94-100. 3. Midtbø KA. Effects of long-term verapamil therapy on serum lipids and other metabolic parameters. *Am J Cardiol*. 1990;66:131-1S1. 4. Fagher B, Henningsen N, Hulthén L, et al. Antihypertensive and renal effects of enalapril and slow-release verapamil in essential hypertension. *Eur J Clin Pharmacol*. 1990;39(suppl 1):S41-S43. 5. Schmieder RE, Messerli FH, Garavaglia GE, et al. Cardiovascular effects of verapamil in patients with essential hypertension. *Circulation*. 1987;75:1030-1036. 6. Midtbø K, Lauve O, Hals O. No metabolic side effects of long-term treatment with verapamil in hypertension. *Angiology*. 1988;39:102S-1029.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol and propranolol clearance may occur when either drug is administered concomitantly with verapamil. A variable effect has been seen with combined use of atenolol. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in an increased sensitivity to lithium (neurotoxicity), with either no change or an increase in serum lithium levels; however, it may also result in a lowering of serum lithium levels. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Verapamil may inhibit the clearance and increase the plasma levels of theophylline. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. There was no evidence of a carcinogenic potential of verapamil administered to rats for 2 years. A study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes, reversible non-obstructive paralytic ileus. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, galactorrhea/hyperprolactinemia, increased urination, spotty menstruation, impotence.

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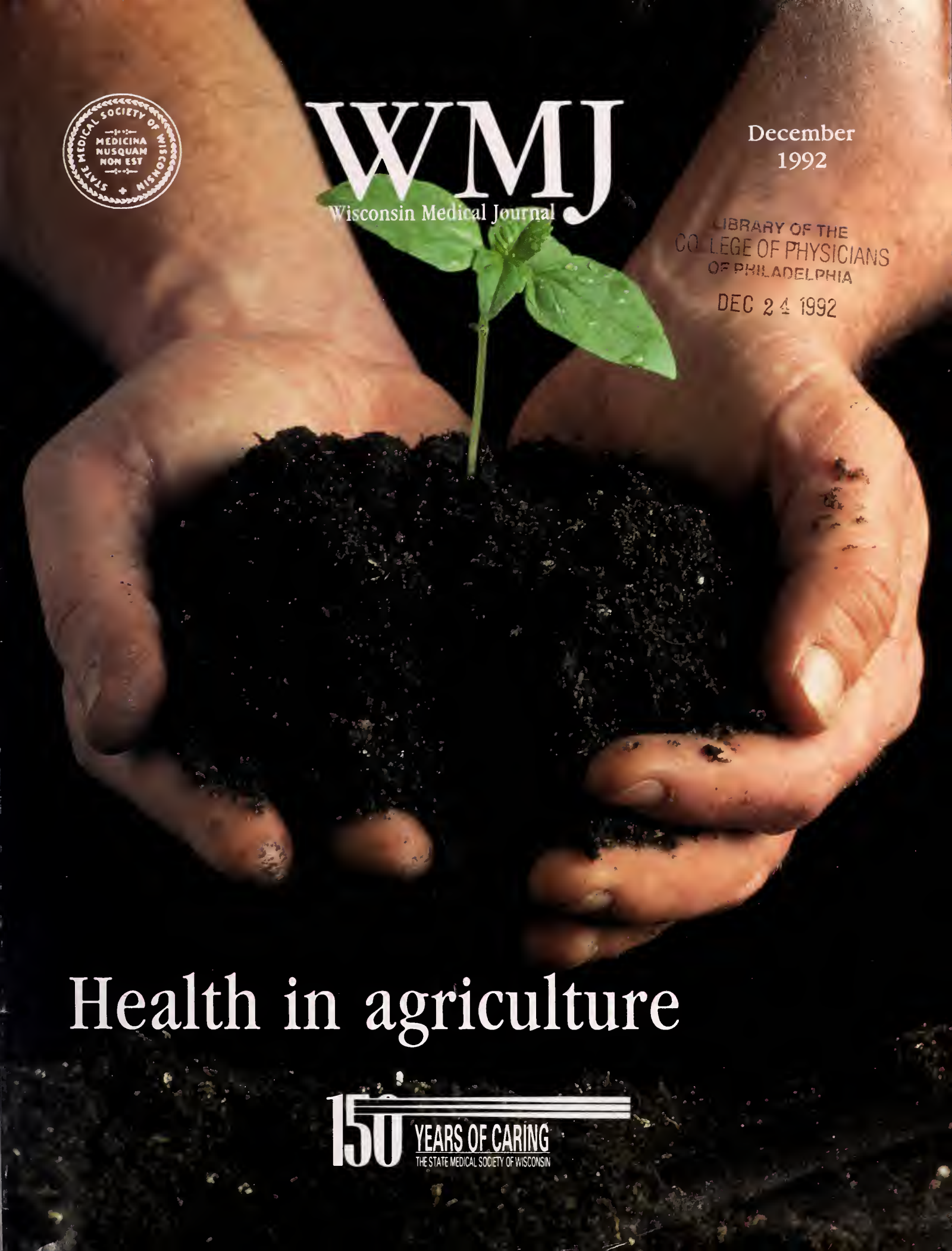
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Contents

December 1992 Vol. 91 No. 12

Opinions

665 *President's page*
Happy holidays
by William J. Listwan, MD, West Bend

666 *EVP report: The view from here*
Health care reform: the future is now
by Thomas L. Adams, CAE, Madison

670 *Editor's note*
The last dance
by Russell King, editor

670 *Soundings*
In the nick of time
by Eugene E. Eckstam, MD, Monroe

671 *Letters*
Awareness helps
by Nicholas L. Owen, MD, WAMD and Susan Wood, deputy director Bureau of Quality Compliance

150 years of caring

673 *A presidential perspective*
Is anyone listening?
by William Listwan, MD, SMS president

675 Why group practice? A young physician's answer
by Susan Turney, MD, Marshfield

678 The nature of university practice
by J D Kabler, MD, Madison

679 Large group or small: a family medicine perspective
by Kay Gruling, MD, Wausau

681 *An interview with the dean*
Medical schools are adapting to the future
by Shari Hamilton, assistant editor

684 A glimpse into our past
by Richard D. Sautter, MD, medical editor

Socioeconomic

685 *Public health*
Promoting occupational health in agriculture at the University of Wisconsin-Madison
by Larry J. Chapman, PhD; Ronald Schuler, PhD; Terry L. Wilkinson, PhD; and Cheryl A. Skjolaas, BS, Madison

688 Physician-Citizen of the Year nomination letter

Organizational

689 Teens seek answers about AIDS and HIV at SMS Workshop on Health
by Shari Hamilton, assistant editor

693 *Giving health care a human face*
A new program gives the public a peek at what it means to be a doctor
by Cheryl McCollum, SMS field representative

695 Madison physician joins global fight against pollution

696 Physician briefs

697 CES Foundation donors

698 County society news

698 Obituaries

701 Index to articles: 1992

Our cover: The UW is promoting occupational health in agriculture (see page 685). Photo by Comstock Photos, New York.

Wisconsin Medical Journal

The *Wisconsin Medical Journal* (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin and is devoted to the interests of the medical profession and health care in Wisconsin. The managing editor and editor are responsible for overseeing the production, business operation and contents of the journal. The editorial board, chaired by the medical editor, solicits and screens all scientific, special and soundings articles. The chair provides leadership for the editorial associates and comments on both editorials and letters to the editor. Although letters to the editor are reviewed by the medical editor, all signed expressions of opinion belong to the author(s) for which neither the *WMJ* nor the SMS take responsibility. The *WMJ* is indexed in Index Medicus, Hospital Literature Index and Cambridge Scientific Abstracts.

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President's page

Happy holidays

WHILE TRAVELING across Wisconsin as the SMS president, I have come into contact with many physicians that I had not met before. Almost without exception, the meetings have made me feel good, and even inspired me. During this holiday season, I wanted to take the opportunity to reflect on this past year and to share some of my good feelings about our profession with you.

The reason these encounters with other physicians make me feel good is that dedication, hard work, and concern for patients are the norm, not the exception. The old saying that sometimes we can't see the forest for the trees may be true. Sometimes we direct our attention to the physician who is greedy and self-serving and forget that the majority of physicians are neither. Sometimes our attention is focused on the significant number of people who may have difficulty getting access to health care, and forget about the majority who do have access. Sometimes we are inundated by negative statistical indicators that allegedly tell us about the poor quality of health care in our country, and forget about all of the high quality health care that is being provided. We need to remember and appreciate all of the good things that are happening around us in our profession.

No, we are not a perfect profession. No, we have not single-handedly solved all of the problems of health care delivery in the United States. Yes, there is room for improvement in our individual practices and in the medical profession as a whole. This should not, however, detract from the pride we feel in our profession and in ourselves as physicians. The majority of physicians are dedicated to their patients' welfare, and the majority of Americans do have access to quality medical care.

I am particularly proud of Wisconsin physicians for the following reasons:

William J. Listwan, MD

The good health of the people of Wisconsin.
A recent release by the Northwestern National Life Insurance Company rated each of the 50 states based on 17 components that measure lifestyle, access to health care, occupational safety and disability, disease and mortality. Wisconsin ranked third out of all 50 states in 1992 (*AM News*.1992;Oct 5:26.). We should all be proud to be part of a health care system that has helped the people of Wisconsin be so healthy.

Enthusiastic support for patient-oriented programs.
Physician participation in PartnerCare, the program pioneered by the SMS and the Wisconsin Coalition of Aging Groups to help those on Medicare with low incomes, is a model for other states. The majority of the elderly in Wisconsin, with incomes under $19,000 a year, automati-

Continued on next page

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Continued from preceding page
cally receive PartnerCare cards which are now honored by more than 4,500 physicians who are actively treating Medicare patients in Wisconsin.

This same physician enthusiasm for issues that benefit patients is apparent in the area of domestic violence. Physicians around the state are becoming more aware of and are appropriately helping their patients who are involved in relationships of threatened or actual violence.

Physician participation in community activities.
Wherever I go in Wisconsin, I see involved physicians helping others in their community. I feel proud when I see Dr Al Theiler, of Kiel, honored by his Kiwanis Club; Dr Kevin Fullin, of Kenosha, working with his local Family Shelter; and Dr Paul Grossberg, of Madison, talking to a hall packed with middle school children about HIV/AIDS. Our state is full of examples of dedicated physicians reaching out to their communities.

Let's all keep working with others toward solutions to some of the problems that confront our society. We must continue to be introspective and reflect on some of our shortcomings individually and as a profession; but let's not let this inner reflection keep us from feeling very proud about all of the good things that we have accomplished individually and as a profession. Keep up the good work and keep on having fun.

Have a happy holiday season.

EVP report: The view from here

Health care reform: the future is now

Nobody likes the current system of health care delivery and financing. Patients hate it, doctors hate it, insurance companies hate it, employers hate it, and politicians are learning to hate it. It wastes time. It wastes millions of precious health care dollars. It violates the physician-patient relationship. It threatens the financial strength of too many businesses. It leaves too many people without coverage. It threatens the economic and physical health of too many families. And it encourages too many people to play shell games, shifting costs and responsibilities from one group to the next.

If the preceding paragraph sounds familiar to you, you either heard my address to the SMS House of Delegates last April or read it in the July *WMJ*. Nearly a year later, the sentiments expressed are no less true. Health care reform was a major plank in the platform of most of the politicians who ran for office in November, and of almost all of those who won. The national demand for reform is one of the big reasons there will be so many new faces in Washington next month.

Federal reforms, however, will come slowly. The processes of fashioning and implementing a health care reform proposal that will both win approval from Congress and actually work toward its objective will take time. Lots of it. In fact, there are signs that a truly national system is not a priority for the Clinton administration. Health advisors to the president-elect have been visiting states with reform programs, including our neighbor across the Mississippi, and there is speculation that Clinton may support a more flexible series of state-specific reforms as long as they meet federal objectives. (It is fair, however, to expect Clinton to continue advocating practice parameters and spending caps–already he has asked President Bush to issue a tough regulation preventing states from using bookkeeping loopholes to collect billions

Continued on page 668

Thomas L. Adams, CAE

Health care reform task force

John Beasley, MD of Madison
Carl Getto, MD, of Madison
Duane Koons, MD, of Viroqua
Bradley Manning, MD, of Madison
Kathryn Nichol, MD, of Madison
John Petersen, MD, of Milwaaukee
Robert Phillips, MD, of Marshfield
Marcia Richards, MD, of Milwaukee
John Scott, MD, of Madison
Robert Sellers, MD, of Superior
Kenneth Viste, Jr, MD, of Oshkosh (chair)
Roger von Heimburg, MD, of Green Bay
Erik Gundersen, of Madison, (medical student)

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Continued from page 666
of extra dollars from Medicaid. Bush complied.)

This window of opportunity to fashion the future of health care in Wisconsin gives new meaning to the work of the SMS Task Force on Health Care Reform. It should also give the reform plan the task force produces a real fighting chance of being enacted and making a difference.

In my annual meeting speech, I said that I believed "that the leadership of this society has the foresight and knowledge to take the lead role in designing a unique Wisconsin response to reform of the health care delivery system," and the Board of Directors proved me right when it formed this task force. Chaired by Kenneth Viste, Jr, MD, of Oshkosh, the task force has marshalled the forces of intelligence, creativity, and wisdom. Together, the members of this task force are forging a new Wisconsin idea, a unique and exciting course of reform for our state's health care delivery system. The task force has been meeting regularly, tackling some of the most formidable agendas I have ever seen, and enduring a grueling pace of work.

The fruits of the task force's labors will be unveiled, pending approval from the SMS Board of Directors, in late February. I will caution you now that a reform plan that does not involve compromise is doomed to failure, and the task force is not interested in lost causes. Not everything in the reform proposal that emerges this spring will make every physician in Wisconsin shout with joy. The hallmark of diplomacy is compromise, and the nature of compromise is that all sides sacrifice something for the larger good. Physicians will have sacrifices to make. Given the composition of the task force, however, I am confident that the balance of rewards and burdens will be both fair and prudent.

Some among us may be tempted to quibble with particulars in the plan, others may balk at the concessions they are asked to make and be tempted to break ranks. Either response would be a mistake. We have made a point of publicizing the names of the task force members and their monthly agenda items, and of encouraging SMS members to share their ideas and values with the task force. And I echo that call here: The time to express yourself is now, while the plan is still being formed.

Once the plan is made public, it will be important for us to stand united behind it. As I forecast last spring, "The question will be whether we have the courage to match our convictions. For the sake of the profession ... I trust the answer is affirmative."[150th]

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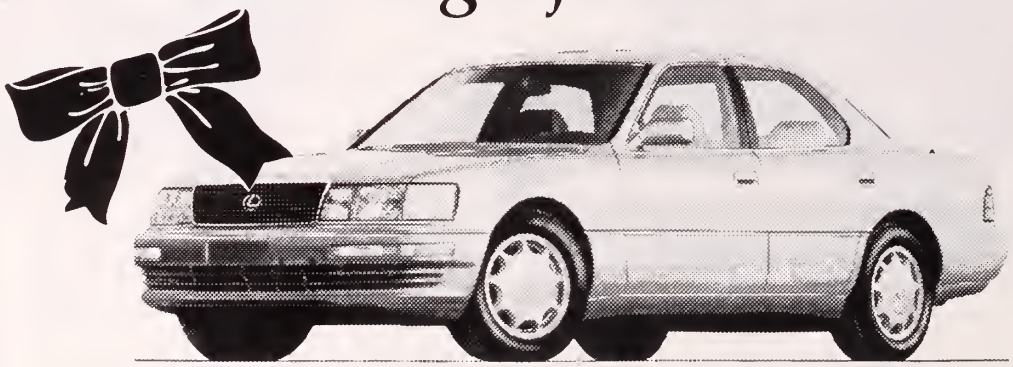

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Editor's note

The last dance

During the past year, the *WMJ* has helped the SMS celebrate its 150th anniversary in a manner consistent with its characteristic dignity. Starting with an article by Earl Thayer, the former SMS secretary-general manager, that drew on original research to set straight the historical record regarding the first SMS president, the *WMJ* brought you a monthly feature story on physicians and institutions of historical stature in Wisconsin.

As a companion piece, the *WMJ* medical editor, Richard Sautter, MD, gave you a monthly "Glimpse into our past." This lively column was sometimes witty, sometimes profound, sometimes astounding, but it was always good reading. We hope you've enjoyed the 12-month journey down memory lane.

To bring the 150th anniversary to a close, the *WMJ* asked several physicians from various styles of practice to tell us about what medicine is like for them in 1992, and what they see for medicine in the coming years (see page 673). It is an interesting collection of articles that begins with SMS President William Listwan, MD, suggesting that medicine's past has important lessons for its future. As Longfellow wrote in *The Ladder of St Augustine*:

"Nor deem the irrevocable past
As wholly wasted, wholly vain,
If, rising on its wrecks, at last
To something nobler we attain."

– Russell King, editor[150th]

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Soundings

In the nick of time

Eugene E. Eckstam, MD, Monroe

A week before Halloween in 1957, I received an urgent call from a family physician who practiced in a small town 10 miles away. He told me a boy had been shot in the chest and he would be at the hospital with him in 10 minutes. He was! Another boy and he had been examining a .22 caliber pistol in the front seat of a car a block from the physician's office.

This was before the now customary emergency medical services were started in this area and the physicians went to the scene of the accident. Because of the semirural area, a short transport time was possible. It was also before the era of long preoperative stabilization and preparation. The operating room was ready when he arrived.

White flat plates of his chest and abdomen were taken in the x-ray department, intravenous lines were inserted and blood samples taken, especially for crossmatch. He was in the operating room in about 2 minutes, and was stripped of his clothes and anesthetized simultaneously.

The x-rays showed only a small pneumothorax, the point of entry being just below and medial to the right nipple. The bullet shadow was over the left kidney. Its likely path was a devastating thought.

Since the chest was reasonably stable, the initial incision was made in the upper midline of the abdomen. Some dark blood was oozing from a hole in the central diaphragm, not enough to cause concern now. The hole through the left lobe of the liver was closed top and bottom. The bleeding left gastric artery was double suture ligated and the hole in the lesser curvature of the stomach was closed.

The omentum was divided from the colon so the stomach could be elevated and the path followed further. As this was done, a huge amount of blood that had been trapped in the lesser sac gushed out and poured onto the floor. The anesthesiologist reported no pulse or blood pressure, but there was a heart beat felt through the diaphragm. A finger pressing

the aorta against the spine as it came below the diaphragm stemmed the flow of blood as multiple transfusions were frantically pumped in.

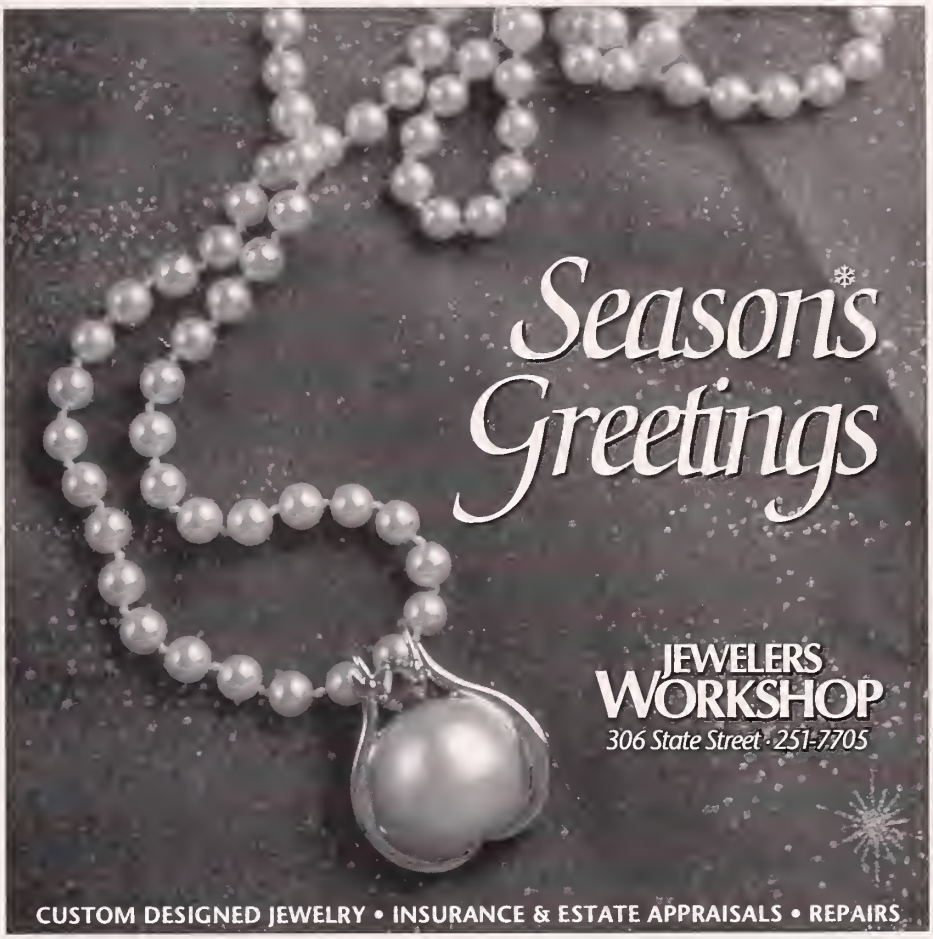
When things stabilized in a few minutes, a search was made for the bleeding site. It was the splenic artery, which was stick-tied on either side of the hole. Aortic tamponade was no longer necessary.

Amazingly, the splenic vein and the pancreas were spared. A small hematoma was seen inferior to the pancreas and extending posteriorly to the left kidney. Exploration of the upper posterior kidney, however, showed it was not injured and the missile was further away than the exploring finger could reach. It was allowed to remain. The diaphragmatic opening was still oozing some dark blood. After the abdomen was cleansed, drained and closed, attention directed to the chest.

The portal of entry was excised and the top of the perforated middle lobe of the right lung was excised. The opening in the pericardium was excised and enlarged. To my surprise, there was a superficial groove gouged out of the ventricle by the bullet and a small branch of the main coronary artery was pumping blood. This was controlled with a fine suture ligature on either side. The chest was closed with drainage. After 6 pints of blood, and after 2.5 hours of surgery, the patient was stable and awakening.

He developed a small bowel obstruction a couple weeks later and simple division of an adhesive band relieved it. Otherwise, the rest of his recovery was totally uneventful.

Five years later, the family sent me a note saying that he had passed his army physical and was in service! He visited me earlier this year and he appears very healthy and muscular. He is an emergency medical technician and a fire fighter in another city. There are no symptoms relating to the gunshot wound that almost killed him. I feel this is one of the two times in my surgical career that I got there "in the nick of time."[150th]



Letters

Awareness helps

To the editor: Several Wisconsin physicians are involved in a task force established by the Department of Health and Social Services studying the distribution of care of disruptive patients between hospitals and long-term care facilities. A discussion at the fall Wisconsin Association of Medical Directors' meeting highlighted the discrepancy between care given these patients and the regulations governing the care in hospitals and long-term care facilities respectively, the latter being far more restrictive.

Achievement of patient's control in the hospital with physician or pharmacologic restraints cannot be continued in the long-term care facility after transfer and, therefore, a trial without restraints should be accomplished in the hospital prior to patient discharge.

Awareness and participation on the part of Wisconsin physicians will help to alleviate this problem.

–Nicholas L. Owen, MD
WAMD
–Susan Wood, deputy director
Bureau of Quality Compliance[150th]

Medical Writing Contest

Contestants:

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- Residents actively training in Wisconsin

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- Presentation at the 1993 SMS Annual Meeting

Rules:

- Subject matter must fall within the parameters of scientific medicine: clinical, case report, research and review
- Paper must be original, unpublished, and credited to one author (although multiple authors may be listed)
- Limited to 10 pages, typewritten, double-spaced, 1-inch margins
- Illustrations are encouraged, but must be included in the 10-page length limit
- The Editorial Board of the *Wisconsin Medical Journal* serves as the panel of judges and has final authority in all decisions

Criteria:

- *Scientific merit:* research methods, data analysis, subject or patient population selection, control of variables, literature analysis
- *Applicability:* usefulness of results to private practitioner, academician, researcher
- *Content:* depth of analysis, continuity of discussion supporting the main thesis, feasibility of conclusions
- *Innovation:* uniqueness of idea, creativity, improvement of existing techniques, previously undiscovered data, advancement of basic understanding
- *Organization*
- *Clarity of writing*

Deadline: Entries must be received by the *Wisconsin Medical Journal* no later than February 19, 1993: PO Box 1109, Madison, WI 53701

A presidential perspective

Is anyone listening?

William Listwan, MD, SMS president

During my inaugural address, I drew a number of parallels between the practice of medicine now and 100 years ago. In 1892, the public–including the governor of Wisconsin–were critical of our income, and medical malpractice lawsuits were considered a pressing problem for our profession. Traditional allopathic physicians were surrounded on all sides by other health professionals who kept threatening their turf. As many as one third of practicing physicians at that time were homeopaths, eclectics, hydropaths, or just out and out quacks.

Although some things do not change, there are obviously many things that do change. I can still remember the great emphasis that was placed on percussion and palpation of the chest as part of our physical diagnosis class sophomore year. Chest x-rays were readily available and were being obtained routinely, but our instructors kept insisting that we learn how to check for fremitus, whispered pectoriloquy, and egophony. We thought the whole exercise was rather archaic and quickly learned to rely on a chest x-ray rather than our skills with percussion and palpation. Technology was replacing bedside skills.

In the early 1970s, specialization picked up steam and when I finished my residency training in 1974, the majority of the internal medicine residents were going into a subspecialty rather than general internal medicine. With the increasing number of procedures available to subspecialists, and subsequently higher incomes, this trend has accelerated until it has approached the speed of light. Family physicians, general internists, and pediatricians may some day have a display in the Smithsonian in a section near the original Model A Ford.

I think that one of the negatives of the increasing specialization is a decreasing ability to communicate with patients. Patients either refer themselves to a specialist, whose main interest is in one particular anatomical area of the body, or are referred because it is easier and quicker for the primary physician to refer the more complicated patients than to spend time listening. A patient with nasal symptoms may be referred to an ENT specialist when the real reason them came to the office was to talk about their marital difficulties. The stuffy nose was only an excuse to make their visit "legitimate." People don't always come into the office and state their most important concern when they talk to your receptionist or nurse.

New drugs, especially antibiotics and antihypertensives, flood the market place and have given us a wide range of medications that can be used to treat disease. Laboratory studies, including the ability to monitor drug levels, have expanded our abilities to more safely and accurately diagnosis and care for the very sick patients. Diagnostic imaging now makes available in almost every community exquisite detail of internal organs that would not have been dreamed of 15 years ago.

Along with this increasing sophistication and technology has come an increasing reliance on the technology itself. Unfortunately, we seem to have lost the ability to talk to the patients. Although the ordering of tests may be preceded by an office visit, the tests seem to be inevitable and frequently are normal or discover an unexpected abnormality that is not responsible for any of the patient's problems. This leads to further testing and needless anxiety. The real problem may never be addressed.

I know that in my practice, in the interest of speeding up the encounter, I frequently direct my questions to the patient and invite simple yes or no responses. I actually become somewhat impatient if I get a prolonged, circuitous, rambling reply. During my residency I was in the habit of asking two or three questions at the same time and then

Continued on next page

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going back to explore in detail only if I received a positive response. For example: "Have you had any trouble with chest pain, shortness of breath, or ankle edema?" In the interest of efficiency, listening to the patient sometimes fell by the wayside and attempts were made to limit the verbal exchange with the patient.

I have been very interested in the number of articles I have seen recently that deal with listening to the patient, interview techniques and the appropriate use of physical diagnosis.[1-5] Yes, sometimes even without an MRI scan! At the recent Wisconsin Society of Internal Medicine/American College of Physicians meeting I attended a talk by Aaron Lazare, MD, about "Shame and Humiliation in the Medical Encounter." He spent a great deal of time talking about the interaction that goes on between the patient and physician at the time of the medical encounter and the significance of this interaction.[1]

The physicians of 100 years ago had to rely on their listening skills, their ability to evaluate the interaction that was going on, and the basics of a physical examination to help their patients. Perhaps percussion and palpation of the chest served a purpose other than to simply differentiate normal lung from pneumonia or effusion. Maybe we are starting to rediscover our roots. If we all learn to listen better, trust our instincts, and appropriately use the technology that is available to us, we will be better physicians than those who use only the technology. By being responsive to what the patient tells us, the patient's fears, and the environment in which the patient lives, we will be more successful as physicians.

I think that listening to the patient is something that all of us need to develop further. Not only the specialists, but also the primary care physicians, who pride themselves on already listening.

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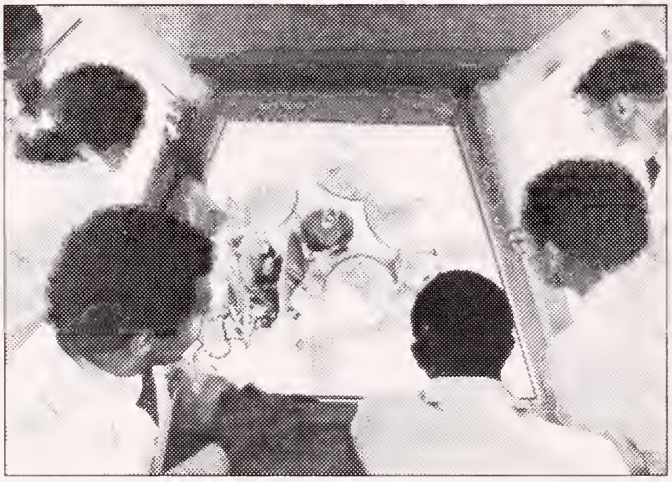

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Why group practice? A young physician's answer

Susan Turney, MD, Marshfield

I REMEMBER WELL the day I decided I wanted to become a doctor. It was a cold, blustery, winter day in northern Wisconsin. I was sitting on the floor in my kindergarten classroom staring out the window as my teacher went around the room asking each of us what we wanted to be when we grew up. I patiently waited my turn until, at last, Mrs MacDonald turned and queried me regarding my future career. I told her that I wanted to become a doctor. She responded in a very quiet voice that I was obviously mistaken and that I must mean that I wanted to become a nurse. I quickly responded to her statement, but much more firmly the second time, stating again that I wanted to become a doctor.

The factors contributing to my decision are not at all clear to me now. I did not come from a medical family and my experience with physicians was very limited. My only contact with our family doctor, up to that point, was going with one of my friend's mothers to help clean the doctor's office, or on rare occasion our family doctor making house calls for the usual childhood infectious diseases.

Our small town's physician was held in highest respect by the local people. He was educated, compassionate, and tireless. He provided for patients and families in sickness and in health. He provided his care with dignity. He provided his care with his heart and hands. Until the time I entered medical school, this is the type of physician I wanted to be.

It was not until I was in my third year of medical school and looking at residency programs that I realized that I most likely would not become the type of physician which for years I had held in my dreams.

My mentors from medical school were very similar to my home town doctor. They were educated, compassionate, and tireless. These physicians, however, were practicing at the forefront of medicine. The evolution of technology was changing at break-neck speed, and specialty areas of medicine were developing at an equal rate. Although we were not specifically told to refrain from a career in general practice, in many subtle and not-so-subtle ways we were encouraged to go beyond simply serving an internship and hanging out our shingles. We were encouraged to actively pursue a course of training in a specialty area.

After rotating through the various clerkships, I realized that in spite of all available specialty areas of training, the opportunity in family practice or general internal medicine would best prepare me for solo practice in a rural area.

During my third and fourth year of medical school, I spent several months rotating through various clerkships at St Joseph's Hospital and Marshfield Clinic. Much of my time was spent in services that provided a great deal of primary care. I was very impressed with the practice of state-of-the-art medicine in a rural setting and interviewed for a position in the internal medicine training program.

Having matched for the residency in Marshfield, I started my internship with some uncertainty. My expectations for this program, however, were still to prepare me for solo practice in a rural setting.

Prior to my completion of internal medicine training, many of my colleagues accepted the challenge of specialty training or pursued a career in academic medicine. I, however, had made a decision to practice medicine in a rural setting and began the task of looking for available opportunities. My dream for the past twenty-five years was coming to fruition.

In my pursuit for practice location, I found many small towns in rural Wisconsin were very eager to have a physician set up practice in their community. Many offered building space at a nominal rent or other incentives to entice newly trained doctors to practice in their towns.

At this point, I needed to consider all of the essentials for beginning a practice. The complexities of ordering equipment, hiring staff, learning different billing systems, and selecting disability and liability insurances seemed quite overwhelming. I was starting to seek outside assistance through various professional societies when the chair of the section of general internal medicine at Marshfield Clinic asked if I would be interested in interviewing for a position as a general internist. I decided to interview.

Marshfield invited me to assume a staff position at completion of my residency. I accepted this position, but the obvious advantage of practicing in a large group clinic with knowledgeable administrative staff to manage "the business"

Continued on next page

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Continued from preceding page
was not my primary reason for accepting.

The primary reasons for this decision were the availability of high quality primary, as well as specialty care, the needs of my family, the rural location, and the geographic proximity to my parents and siblings. I could now practice state-of-the-art medicine in a rural setting.

The day I started practice, I had a fully equipped office, trained assistants, complete ancillary services, experienced professionals in the business office, and human resource personnel to make sure all insurance needs were covered.

I spent the first few years at Marshfield building a practice primarily from the surrounding community of patients wanting a family doctor. It took many encounters for them to realize that I was there to address their medical and psychological needs. I was also there to discuss preventive care, as well as manage acute medical problems that arose.

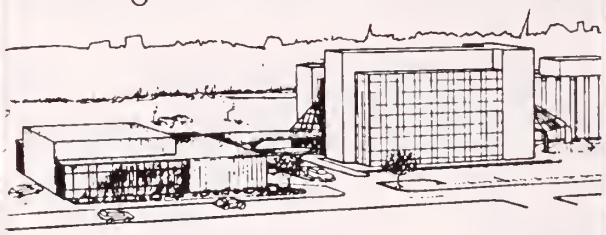
This practice was very satisfying for many reasons. There were, however, many socioeconomic changes beginning to take shape. Increasing control from the "outside" was upon us. Liability, risk management, Medicare and other third-party payor regulations, practice guidelines, quality improvement, HMOs, PPOs, etc, were all new terms to me. It was at this time that several of my colleagues at Marshfield suggested I join the Wisconsin Society of Internal Medicine and the State Medical Society to better understand the multiple factors that were to play an ever-increasing role in the practice of medicine.

As I became entrenched in the problems confronting the practicing internist, my awareness of the broader issues facing the medical profession began to multiply. I escalated my participation; it became an integral part of my professional life.

In retrospect, I know joining a group practice was the best choice for me. Being part of a large department in a large multispecialty clinic, I have had the good fortune to be able to have been granted the opportunity to spend time practicing primary care medicine, and to participate in the local, state, and national legislative arena. I believe my contribution is in helping to guide policy, minimizing outside controls, and improving the quality of our professional and personal lives.

I have been blessed. I practice state-of-the-art medicine in a rural setting. I am a participant in the development of the health care system.

Breaking New Ground in Medical Care



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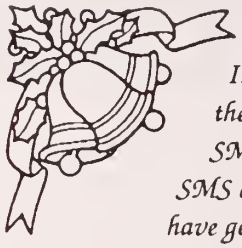

In the spirit of the season, the following members of the SMS Board of Directors and SMS delegation to the AMA have generously donated to the General Student Loan Fund of the Charitable, Educational and Scientific Foundation (CESF).

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The nature of university practice

J D Kabler, MD, Madison

THE PRACTICE PATTERNS in academic medicine are as diverse among themselves as are those in community practice. Academic practitioners vary widely in the proportion of their time and effort devoted to the traditional roles of teaching research, public service, and clinical practice, but nearly all are involved in some combination of these roles. A few have administrative duties, but only a very few are exclusively so employed.

For many in academic medicine, teaching is a substantial, though not the major, role. Teaching can involve many levels of instruction: undergraduate students in nursing, occupational therapy, physical therapy, physician assistants, medical technology and pharmacy; medical students from the first through the fourth years; resident physicians, postgraduate fellows; graduate students; and continuing medical education for physicians, dentists, pharmacists and others. Less formal instruction on topics of current concerns is expected by the public.

Good teaching is hard work, time consuming and demanding. For the clinical teacher, instruction must be a prime priority; when the class meets the instructor must be there, whatever are the other demands, including patient care. Indeed, clinical service is the cancer of instruction. Clinical teaching means supervision of and responsibility for the actions of the students, undergraduate and graduate alike. Not all physicians enjoy or are temperamentally suited for this style of medical practice.

Student evaluation of teachers and teaching is the norm. Substandard teaching is career damaging and superior teaching brings the sort of local and national performance that enhances academic promotability.

Research is highly competitive—locally, nationally and even internationally and few will attain stardom. Additional preparation and study have become necessities to successfully compete for the research grant funding that sustains the researcher's and co-worker's salaries. Failure to attain national peer recognition and approval can abort a career. Nonetheless, the thrill of discovery and satisfaction of scientific

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curiosity are important intangible rewards for the research oriented who succeed.

Academic clinicians must not only be abreast of their field, but ahead of it and contribute to it. This usually means publishing. "Publish or perish" overstates the situation but "scholarly" activity is expected. As compared to community practice, patient care more often emphasizes the complex, unusual and "tertiary" and sub-specialty (even sub-sub-specialty) aspects of contemporary medicine. This places the academic clinician in the ambivalent position of both competition and collaboration with colleagues in the community. Academics generate their own competitors who complete training programs and enter community practice. These town-grown tensions are inevitable and may increase as medical schools become more financially dependent on faculty practice owing to declining income from tuition and taxes.

Both community and academic physicians face the same current increasing regulation, declining reimbursement, increasing competition, and growing turnover of patients and colleagues. Capital resources are scarcer and management more complex. Physician autonomy is a concept of the past.

The hours worked per week, the problems of group and institutional practice, and interaction with individual patients and other physicians are similar for both community and academic physicians.

There are some differences. Academic medicine is a public practice more open to the "media," more vulnerable to multilayered micromanagement by distant masters, and less free to negotiate terms of employment, including income. It is subject to "up or out" rules—failure to attain promotion in 5 to 8 years means departure and promotion is by no means automatic. Ascent up the academic ladder has come to require national peer recognition. This means travel to more national meetings to present papers; whether one regards this as favorable or unfavorable is a personal choice, but it affects family life.

For those who savor and survive academic medicine it is a great career choice. Not every day is Christmas, but every day is different and you can have the singular satisfaction of helping generate the next generation of physicians. "I remember what you taught me; you were my mentor" are among the kindest words of all.[150th]

Large group or small: a family medicine perspective

Kay Gruling, MD, Wausau

Today, the options for the family medicine specialist are varied and bountiful. Choices include administration, urgent and emergency care, research, academic, and front-line primary care. Not only have the variety of non-traditional family medicine options grown, but so have the options within the clinical setting.

As I approached the end of my family medicine residency, I was confronted with the decision of what type of family medicine specialist I would be. For me, deciding on front-line primary care was an easy choice. It was what I had always envisioned. The type of practice setting, however, was not such a clear choice.

All my childhood role models—Marcus Welby, Ben Casey, and my own family physician (all men, of course!)— had been solo practitioners. They were supermen—heros. They attended to all the needs of their patients. (Of course, they always had some wonderful person to care for all their personal affairs.)

This ideal was strongly instilled in me. But real life was not the same as TV life. Medicine was not the same in the 90's as it had been in the 60's and 70's. There was a conflict within me: ideal vs practical.

So I carefully considered my options in the community in which I had chosen to live: solo, various arrangements of small family medicine groups, and a large multi-specialty group. After much consternation, I decided I could be my version of an ideal physician and enjoy the benefits of a large group.

Like all options, a large group has its pros and cons. Family life or personal time, as well as a successful practice, are important to today's physicians. A large group enables you to have more choices with regard to scheduling, vacation, conferences, and practice style. Since there are fewer people available for cross coverage in a small group setting, you are often locked into certain scheduling patterns.

For instance, one small group I considered had the clinic schedule divided into 2 hour blocks that were continually rotated among the physicians. While it sounded like a flexible schedule, it in fact "locked" you into a schedule. If you chose an alternate approach, the whole scheduling system would collapse.

In a large group, you can generally schedule as desired as long as it doesn't impose on others. I currently offer an evening clinic to my patients and leave earlier on another day. Despite the fact that none of my other partners does this, I still am able to schedule in this manner without creating difficulties for my partners.

Solo practice, of course, allows for the

Continued on next page

Continued from preceding page
greatest flexibility in practice style. But in comparing small groups and large groups, I feel that large groups offer the greatest degree of flexibility in practice style.

In a small group setting, it is important that the general philosophy and practice style be similar. In a larger group, just by virtue of the sheer number of physicians, you have greater anonymity and, therefore, greater freedom in practice style.

The larger group setting is more stable in situations in which conflicts arise among physicians. If several physicians leave a small group, especially unexpectedly or in rapid succession, a large burden—both financially and in regard to patient load—must be bore by the remaining physicians. A larger group can better absorb the costs and demands of such conflicts and losses.

Benefits are generally outstanding in the larger group setting. Management of the benefits is generally performed by someone with experience in the area of benefits, rather than physicians trying to become experts in the area in their free time. The overall benefit package typically is not as predictable in a small group, but, nonetheless, can be good.

Administrative tasks in the large group are generally performed by people who have education and experience in business. The administration is generally overseen by a board of physician members of the clinic. This is a benefit to those who prefer not to spend a lot of time dealing with the day-to-day operation of the business of medicine. For those who like to be a part of every business decision, the small group setting is a better choice.

In setting policy, the small group is more likely to closely resemble the individual physician's thoughts on policy as he or she has a large voice in the policy-making process. On the other hand, the individual in the large group setting is more likely to be at odds with some of the policies of the organization as one voice does not have as much influence.

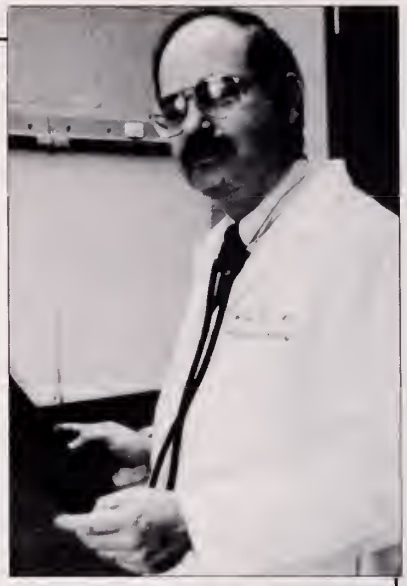
Generally, a greater number of patient services can be provided at a large clinic. This proves to be more convenient to both patients and physicians. Some might claim that it also provides more opportunity for the patient to become lost in the system and to have a less personal experience. I feel that good planning and organization, as well as properly chosen staff, can generally prevent this from happening.

A wonderful benefit of a large, multispecialty group is the instant consulting service available from a variety of fields. You are able to walk down the hallway, x-ray in hand, to review with the orthopedists. Or, you can ask the neurologist to quickly "peek" at an unusual neurologic finding. Some might feel that this same benefit is also a curse in that you are obligated to use the group's consultants exclusively. Certainly, you are probably more likely to refer within the group, but you're definitely not obligated. (Besides, it's against the law to mandate referrals.) A good physician will refer his or her patients to the best consultants despite the practice setting.

The hours of work you perform each week certainly can be influenced by the practice setting. Some feel that family physicians and other primary care providers do not work as hard in large group settings compared to those in small group settings. It is thought that they are carried by the higher paid specialties. Although this may be true in some cases, I don't feel that the two go hand-in-hand. Good physicians are conscientious and work hard in any practice setting.

I am enjoying medicine in a large group setting. Would I enjoy it in a small group? Probably. I just enjoy medicine. There will always be the pros and cons in any practice setting. For me, the large group setting offers more advantages–especially in terms of stability, flexibility, options, and the ability to be as involved or uninvolved in the organization as I care to be.

What about the future of family medicine in the clinical setting? I feel that all types of settings—solo, small group and large group—will survive. Family physicians serve a diverse patient population in a variety of locations. A single type of practice setting would not be possible or beneficial.[15,16]



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An interview with the dean

Medical schools are adapting to the future

Shari Hamilton, assistant editor

In this highly charged political year, you might think medical school officials would be sitting back and waiting for the chips to fall. But that's just not the style of Laurence Marton, MD, the new dean of the University of Wisconsin Medical School. Dr Marton is eager to catapult UW to an even higher level of excellence. It's a job with more than a few challenges.

The University of Wisconsin Medical School has long enjoyed a good reputation, ranking in the top 25% of the nation's physician education programs. Six months into the job and a long way from his former home in sunny San Francisco, Marton is ready to take UW even higher. He's focused on bringing the Big 10 school into the top 10%, a position he says he has trouble believing the UW has not already achieved.

"Surprising to me, it's not in the top 10% of medical schools in the country because the potential of the campus and the faculty and the historical perspective of what's gone on the Madison campus would make it seem natural that the medical school would really be a leader rather than just in the upper echelon," he said.

Of course, there are a few hurdles blocking the assent, namely a lack of financial support for programs and staff. The UW Medical School is currently searching for six department chairs. "We have had absolutely excellent candidates for our chairs," Dr Marton said, adding that the reputation of the university and the city have led many to apply for the slots. "But (the applicants) are not willing to come for nothing. They are vital people in the prime of their careers who would come only if they have the opportunity to build something that is creative, innovative and exciting. They are not looking for a place to retire."

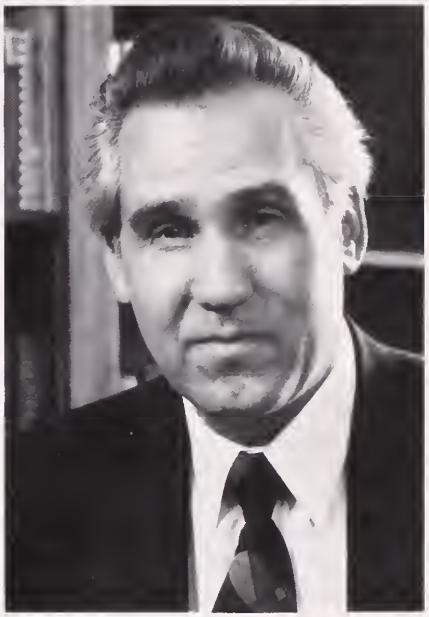
Dr Marton says that medical school chairs tend to be more permanent than chairs in other academic departments so this is, indeed, an important juncture in terms of the school's future. "The choices we make now are critical to the future of the school. We're looking for ways to get an infusion of resources in the short term so we can make appropriate recruitments for our chairs."

Another challenge for the medical school also depends on resources–the medical school is in dire need of more space to train students. "By standard campus criteria which is applied for the University of Wisconsin for various academic programs–which does not take into consideration the special needs of a medical school–we are under-spaced by 225,000 square feet," Dr Marton explained.

"The discretionary funds within the school to bring in new faculty, to create new programs is extremely limited. And I think it's fair to say that the medical school–although I think it's been well appreciated by the people of the state and certainly those who've trained here–has never gotten primary attention of the Madison campus. So I think there needs to a refocus on the medical school in order to move it to the next tier," the dean said.

In Dr Marton's eyes, there seems no question that a failure to strive to improve the institution in these areas would be detrimental to the school's outlook. "If we don't bring it up to where it needs to be and move it on into the future, it will be very, very difficult to even maintain its present standing within the top 25%," he said.

As medical schools across the country look at and implement new ways to educate physicians to meet the demands of fast-evolving technology, UW has also undertaken a curricula review; a retreat is planned with representatives from other universities and colleges. Dr Marton said the review will be accomplished within the next 1 to 2 years. "We want to keep students abreast of technological, social and economic issues that will affect not only their education but their ability to practice as physicians in the future."



Laurence Marton, MD

Elements in the curricula are expected to change slowly. "We're not going to create a plan that indelibly marked for the next decade. What we're going to try to do is set in place something with a constant change mechanism built into it. We want something that is ongoing, alive, and evolutionary," Dr Marton said.

Beginning with a restructuring of the dean's office, Dr Marton is also working to bring about some changes in the culture of the medical school. The medical school will now have three assistant deans–one for students, one for curricula, and a third focused on the recruitment of under-represented minorities.

In addition, there will be a new emphasis on psycho-social issues that is ultimately aimed at improving the ability of new physicians to communicate with patients, colleagues, and others. The effort recently began with a faculty lecture

Continued on next page

on gender issues. "We have to sensitize everybody; we can't just say we're going to teach the students. If the culture of the institution doesn't change, then having a lecture series does no good," Marton said.

As these efforts are launched, Dr Marton said, the university will not abandon normal activities. "We are going to try and strengthen the basic science, and increase the connection between our basic scientists and our clinical scientists so we can, in fact, push the borders both of fundamental research and clinical research."

The dean is also struggling, along with other state officials, to make some changes in the review process for University Hospital. The medical facility is now subject to the same review process as all other state agencies. "We want in the hospital setting the ability to respond to the clinical needs that a hospital has to respond to, and quite honestly, the state system is extremely cumbersome. To wait for a 2- or 3-year review process in order to make significant changes is not good for education, not good for research and it's certainly not good for patient care," he said, explaining that the proposal now on the table would maintain UW Hospital as an entity within the state system, yet would free the hospital from meeting some demands for review. The hospital would still be under the direction of the UW Board of Regents and the Legislature could step in any time legislators felt the needs of the state or university were not being met, he said.

In keeping with the mission of the university, Dr Marton and his colleagues are looking beyond the boundaries of the campus and the city to points beyond in the state. Dr Marton says he is troubled that physicians have taken so long to devote themselves to working on solutions to escalating health care costs.

Over the past decade or to so, he said, physicians "should have used part of our creative spirit not only to advance the new technologies or to make cutting-edge fundamental scientific inquiry and increase our knowledge in that sphere, but rather to apply a portion of our intellect to create, in effect, ways to provide health care."

"I am, for sure–and I think the majority of faculty on campus are–devoted to taking a portion of our efforts here on the campus and devoting them not just to the development of additional technical skills in terms of new diagnostic or new surgical interventions or new theory of therapeutic interventions, but also the concept of how does one provide health care in a cost effective, sane, rational manner to our clients or patients."

Marton noted somewhat ruefully that health care has become "big business," with costs approaching levels where some have compared them to the federal deficit. Projections showing that by the mid 1990s, health care costs in the United States will top $1 trillion annually. He has begun to bring together a team, composed of both medical and non-medical faculty, to study health care policy. Marton said this health policy group will differ from many others because it will not be looking at ways other states can address the issues; the focus will be addressing the problems here at home.

> "The choices we make now are critical to the future of the school."

"It's hard to do it locally because then you might have to put some of your ideas into action, and that's a little risky, but I think that's the focus we're going to take. Our hope is that we will work with the physicians of Madison and within the state of Wisconsin and with the legislators and the folks who are providing insurance coverage for their employees and all the appropriate advocacies to find what those issues are, and see if the university can't make some kind of contribution to that. It's not going to come up with the sole answer, but clearly it's a partnership."

As well, the university alone cannot solve health care delivery problems stemming from the shortage of physicians in primary care, according to Marton.

UW is working to direct more students into primary care. Currently, the medical school produces about the national average (30%) of medical students who select a career in primary care. But some experts are saying 50% of medical students should be in this track to meet the health care demands of the future.

"We're going to try to introduce students to primary care as a lifestyle earlier in their careers. We do have a highly successful primary care clerkship given in the third year. One of the concerns is that by the time the students get to it in the third year, they have already determined in their minds where they are headed. So we need to introduce these concepts to them, ideas about the lifestyle, the pluses and minuses long before that," the dean said.

"If we turned every student that we get in from now on into primary care physicians, and took all of our residencies and converted them all into primary care, it still would be well into the 2000s before we got the 50/50 mix out there practicing that we need."

"The answer to this problem is not just training students and getting them to go into primary care. We have to consider how to re-train, if you will, some of the physicians we presently have in specialty care to move into primary care," the dean related, adding that he believes specialists would not have to abandon their specialty, but rather re-focus a portion of their practice on primary care to meet the population's needs.

To devote all of UW's resources to educating primary care physicians as other schools have done would be a mistake, Marton said. "We can't turn everything we do to that otherwise there is no uniqueness to this institution as an institution of higher education and of outstanding research. We have to balance our missions here and try to create the appropriate product for what I believe the University of Wisconsin is all about."

An open discussion is also needed among physicians, Marton said, to figure out ways the statewide physician commu-

nity and the medical school may co-exist and avoid self-defeating endeavors.

That effort is already underway in Madison, where Dr Marton said no more physicians are needed. "Many of the physicians who practice in Wisconsin, and certainly in Madison, are either students of this school, trainees of its residence program, or members of its clinical faculty so that the umbrella of the university really reaches a long way," Marton said. "Of course, the community's become competitive with the university to a certain extent because we've trained excellent people who come out and do most of the things that can be done in the university, and the limited activities that the university uniquely does is much smaller than it used to be in the past. So we need to figure out some way of coexisting in a fashion that allows the university and medical school to persist in the things it must do which is to educate, to do frontline research and to provide health care. We need to figure out how to do it in greater partnership."

Although his work in Madison requires much of his attention, Dr Marton has already traveled to Marshfield to meet with physicians and has plans to visit the Gundersen Clinic and some of Wisconsin's more rural medical practice areas.

"I'm trying to learn," the dean said. "I don't come here with all the answers. I come here with some ideas and a willingness to try and make some changes around here. But the change is going to take a collective wisdom and a collective effort and a decision by the state that, in fact, there is an appropriate reason for the medical school to exist; that the medical school is a true partner in the things that need to take place in the future; and that having a repository of excellence in biomedical research and a cutting edge in clinical care is really something the state (both the Legislature and the general population) wants."[150th]

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A glimpse into our past

Richard D. Sautter, MD, medical editor

When I began writing these monthly columns, I intended them to serve as part of the 150th anniversary celebration for the SMS. They have served that purpose, but to my pleasant surprise, they have also proven popular with you, the *WMJ* readers. Not only have I received several letters expressing interest in and enjoyment of the column, but the early returns on the recent *WMJ* reader survey have given the column high marks.

In theory, this should be the final column, for the *WMJ*'s celebration of the 150th closes with this issue. While I expect that the cessation of this column will rouse no wailing or gnashing teeth, there has been enough interest expressed that I intend to revive it now and then for your periodic amusement.

20 years ago

This was only 20 years ago? A bill was introduced in the Wisconsin Assembly to remove contraceptives from the statutory list of "indecent articles." The SMS supported a bill that called on the Medical Examining Board to "establish standards for certifying individuals who hold themselves out as physician's assistants." The age of legal adulthood was lowered to 18. A US Supreme Court decision on a Massachusetts case was viewed as meaning that Wisconsin's ban on the sale of contraceptives to single persons was unconstitutional and unenforceable. Now we are giving them away—hopefully.

37 years ago

A time of fear. Physicians in Wisconsin and around the country were being sent a publication called *American Soviet Facts*, which contained "up-to-date information" about health care in the USSR published by the National Council of American-Soviet Friendship. But simply receiving this publication in the mail could raise "suspicions of communist sympathies." The *WMJ* warned that "records are kept of persons receiving communist literature," and the AMA advised physicians to write to the publisher, requesting to be removed from its mailing list, and to send a carbon copy of the letter (along with the "propaganda") to the FBI.

55 years ago

The birth of a giant. The Social Security tax took effect Jan 1, 1937, and the *WMJ* summarized the responsibilities of physicians under the act: "1% on 1937 payroll to be paid by employer to the collector of internal revenue, Milwaukee" and "1% on the 1937 payroll to be deducted from the wage of each employee by the employer and paid over by the employer to the collector of internal revenue, Milwaukee." The nose of the camel under the tent.

71 years ago

How wrong he was! Sen Peltier introduced a bill to repeal compulsory smallpox vaccination of school children. The bill died in the Wisconsin Senate. There was no effective treatment for the disease, which killed up to 40% of its victims. The worldwide vaccination program culminated in 1980 when the World Health Organization declared smallpox extinct. Stupidity knows no age.

88 years ago

An opportunity missed. The SMS president asserted that it was "time an effort were made to learn from (elderly) members the history of their lives, and anecdotes of the lives of many who have long since gone. A concerted effort would bring together a wealth of material that will be valuable to the future." He lamented that published papers were the only trace left of some of the founding physicians and urged his peers to create an album "in which shall be preserved the faces of our past and present members, together with biographical notes..." The album was never created; or if it was, it has since been lost. As I skimmed the SMS history for these columns, I was often struck by how scant a record we have of those early decades. "If we delay too long," wrote the SMS president, "much of value will be lost." Indeed.

105 years ago

Once upon a time. The following is a physician's own description of how he treated the head wound of a 12-year-old boy: "Upon examination I found a lacerated scalp wound, bleeding profusely, and after enlarging the same by a free incision, a depressed fracture of the skull, situated on the right parietal bone, involving the superior angle of the occipital bone. The fracture being indented, it became necessary to expose the meninges in removing the partly detached pieces of bone by means of bone forceps and chisel, when a small rent of the dura mater was detected, from which blood oozed out rather freely. After applying a ten per cent solution of chloride of zinc to the wounded surface, which checked the hemorrhage completely, and irrigating the scalp with a one per cent sublimate solution, the wounds were united hermetically with cat-gut sutures, using twisted cat-gut as drainage and the usual antiseptic dressings were applied." Neurosurgery always was a brutal specialty.

122 years ago

A matter of some gravity. A physician delivered a paper at the SMS annual meeting that asserted that the gravitational pull of the Earth was responsible for more illnesses–and could be used for more cures–than most physicians supposed. He hoped that his paper would be taken as "an appeal for better management and less drugs, which course I believe will be found as good in policy as it is in morals..." Among the ailments attributed to gravity: varicose veins, hemorrhoids, post-partem hemorrhage, convulsions, anemia, violent neuralgia, and vertigo. The effect of gravity grew worse. Where would the cosmetic surgeon be were it not for gravity?[150th]

Public health

Promoting occupational health in agriculture at the University of Wisconsin-Madison

Larry J. Chapman, PhD; Ronald Schuler, PhD; Terry L. Wilkinson, PhD; and Cheryl A. Skjolaas, BS, Madison

In December 1991, a Wisconsin farmer was fatally injured while repairing a manure spreader. The farmer had removed the shield guarding the moving machinery parts to work on the spreader mechanism. While his back was turned, the farmer's coat tail became entangled in the rapidly spinning drive shaft. The Wisconsin coroner's report cited a broken neck as the cause of death.[1]

In June 1991, a Wisconsin farmer died while operating a farm tractor. The farmer was using the tractor to pull an old farm truck out of a field. After putting the tractor into gear, the front end rose up and the tractor flipped over backward, pinning the victim beneath.

In July 1989, five members of one Michigan farm family died after consecutively entering a manure storage pit. The first worker was overcome and collapsed while attempting to repair machinery located in the pit. Then, in order, the man's son, uncle, brother, and father each attempted rescue. The Wisconsin medical examiner's reports cited methane asphyxiation as the cause of death.[1]

In June 1986, a Wisconsin grain elevator employee died of complications resulting from long-term, low-level pesticide exposure. This agricultural worker had applied carbon disulfide-based fumigants to grain for more than 10 years. Shortly before he retired, he began experiencing headaches, fatigue, extremity tremor, gait difficulty, and psychiatric manifestations consistent with chronic carbon disulfide poisoning that progressively worsened until his death.

These are classic examples of injuries and diseases associated with agricultural work. Although most farms are exempted from requirements to report work-related injuries and illnesses, there is widespread agreement among experts that agriculture is one of the most dangerous occupations in the United States.[2] Most of the people doing agricultural work are not protected by either federal or state occupational safety and health standards.[2] The majority of farms (89%) are small businesses with 10 or fewer employees and are exempt from compliance with governmental protective labor legislation rules and inspections.[2]

Most people in the farm labor force are not covered by Wisconsin's Workers' Compensation program. An estimated 30% of farm residents have no medical insurance (compared to 16% of the general population), in part because those adults employed in agriculture and their families are less likely to have employment-related coverage than workers in any other industry.[3,4]

Agriculture is the only industrial sector where rates of fatal work injury have remained essentially unchanged for more than 50 years.[5] Nearly half of the machinery-related deaths occurring annually among all workers in the United States involve farm equipment (Table).[2] Certain occupationally related illness rates are elevated in agricultural work. Wisconsin farmers have higher proportional mortality ratios than the workforce average for certain neurologic conditions, asthma, and certain cancers (Figure).[6]

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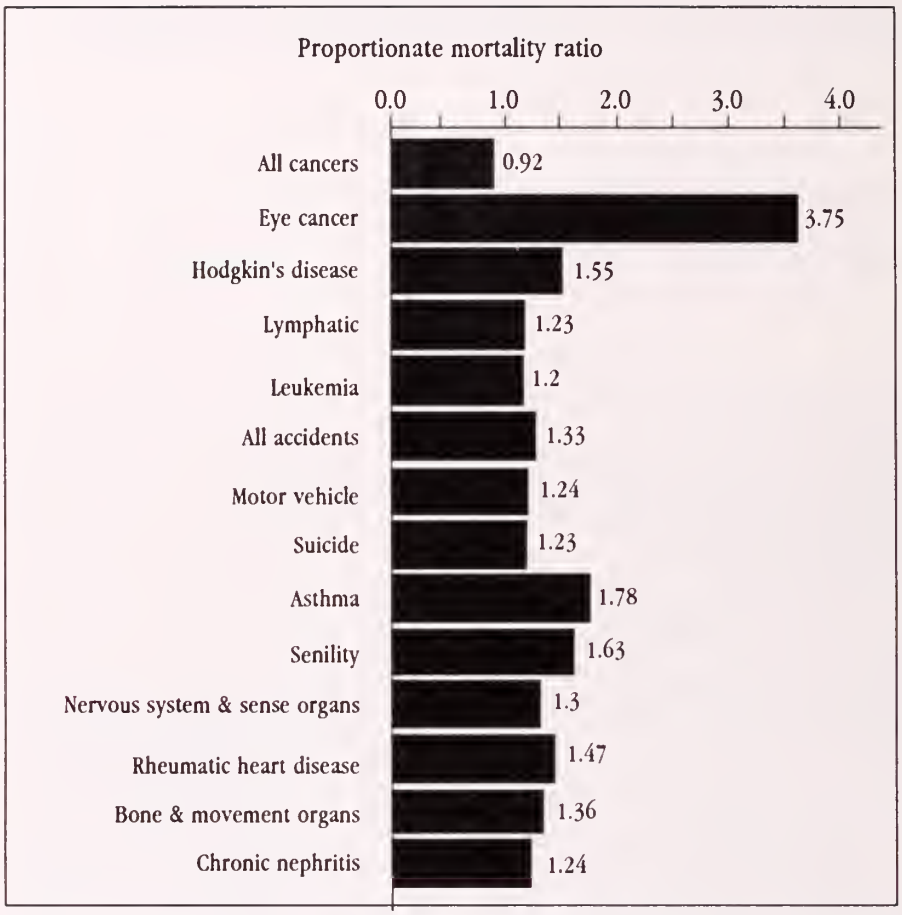
The public health column is not reveiwed by the *WMJ* Editorial Board; it is coordinated by Patrick Remington, MD, and Henry Anderson, MD, at the Wisconsin Division of Health. Chapman is an associate scientist with the UW departments of neurology and agricultural engineering. Schuler is a registered professional engineer, a professor at the UW Agricultural Engineering Department, and the principal investigator for the UW-NIOSH cooperative agreement. Wilkinson is the extension agricultural safety specialist in the UW Agricultural Engineering Department. Skjolaas is the UW-NIOSH outreach specialist. Inquiries regarding the UW-NIOSH Agricultural Health Promotion System project and reprint requests should be directed to: Larry Chapman, University of Wisconsin Agricultural Engineering Department, 460 Henry Mall, Madison, WI 53706; (608) 262-3310. Copyright 1992 by the State Medical Society of Wisconsin.



Fig–Proportional mortality ratios for 36,000 farmers in Wisconsin, 1968-1976. Source: Saftlas A, et al. Am J IndMed.1987;11:119-129.

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Background

Agriculture is Wisconsin's major industry and the state is the national leader in dairy production. Overall, Wisconsin has an estimated 80,000 farms and employs an agricultural production labor force of 110,000 including paid workers and unpaid family workers who work more than 15 hours per week.[7] Fifteen percent of all farm operators in Wisconsin have a second full-time job, and 21% of farm operator spouses work full-time jobs off the farm.[8]

Delivering services and communicating information to farmers is difficult due to the large numbers of small, independent operations and the widely dispersed worksites. Land grant universities in each state operate agricultural extension programs that use agents in offices at the county level to advise farmers about business and production-related information, as well as other topics. Extension programs have long established working relationships in rural communities. The information that agents provide is widely used and highly valued.[9] Extension agents are probably playing the major role in getting occupational health and hazard information to agricultural workers.

Extension programs in some states employ a designated agricultural safety specialist to work with county extension agents. Wisconsin was the first state to hire a specialist in 1943. These specialists, in cooperation with local agents, have traditionally conducted educational programs to improve factual knowledge and attitudes about safety among farmers. In the last decade, however, research evidence and an expert consensus has emerged that more education, greater levels of factual knowledge, and improved attitudes have not reduced farm-related injuries and illnesses.[10,11] Research and industry experience in other occupations has also indicated that training people to behave safely is not usually effective. An alternative approach gaining favor involves encouraging one-time actions that eliminate or permanently correct hazards. Hazard control has a record of proven effectiveness for the prevention of injury and illness in workplaces as well as in homes and motor vehicles.[10,11]

The project

In 1990, as part of a large, long-term commitment focussed on agriculture, the US National Institute for Occupational Safety and Health (NIOSH) awarded funds to the University of Wisconsin-Madison (UW) and 14 other land grant universities around the country. The awards were part of a cooperative agreement program "intended to use the existing network between the land grant university Cooperative Extension Service and the agricultural worker."[12] The new program was entitled the Agricultural Health Promotion System and was established to "translate what is already known about the prevention of injury and disease and turn it into action in the agricultural community."[13]

Under the UW's new NIOSH-funded award, work is underway to integrate the new findings about prevention into the extension programming delivered to the state's agricultural producers. New injury and illness surveillance projects have also been initiated. Activities are being conducted to achieve the following three objectives:

- develop and deliver training to farmers, extension agents, and public health personnel and evaluate it's effectiveness;
- conduct surveillance activities to identify and characterize farm-related injury and disease; and
- select or develop and disseminate new materials for existing college courses and agricultural worker continuing education programs to increase the exposure of students to farm health and safety topics.

Training. Training interventions have

focussed on the key delivery resource, the extension agent. More than 95% of Wisconsin's 305 extension agents completed a baseline evaluation of their farm health and safety relevant activities, their use of existing materials and referral sources, and their attitudes about obstacles to greater program effectiveness.

Hazard identification inspection protocols have been developed and distributed to extension agricultural agents to use with farmers. Agents have also received informational communications about the higher yield of hazard correction over safe behavior training in reducing injuries and illnesses.

A comprehensive compendium of resource material and referral sources for agricultural health and hazards has been delivered to each of the 72 county extension offices.

Hazard information has also been disseminated directly to farmers through brief informational mailings, displays, and presentations at public events.

A sample of Wisconsin farmers are completing evaluations to determine the effectiveness of the new information at increasing factual knowledge, and to determine how farmers use extension agent programming. The evaluations will also solicit farmer attitudes about obstacles to greater program effectiveness. Hazard information dissemination efforts and evaluations are planned for county public health nurses and for vocational agricultural teachers in secondary schools.

Surveillance. Innovative programs have been developed to collect and evaluate fatal injury and illness surveillance data and to provide technical assistance to state and county health officials during on-site investigations. The coroner or medical examiner in each of Wisconsin's 72 counties has begun providing death investigation reports of farm-related fatalities to the UW. Incentive payments to counties are being used to improve the timeliness and data quality of the reports. Farm fatality information from three sources: newspaper reports, death certificates, and coroner or medical examiner fatality investigation reports, is being combined, reconciled, and entered into an electronic data base.

More than 100 coroners and medical examiners and their professional staff have received training in the types of hazards and fatalities common to agriculture in Wisconsin and in the fundamentals of on-site injury investigation procedures for farm-related deaths. Coroners and medical examiners also received an illustrated guide to agricultural equipment including standard terminology for items, hazards and safety features, descriptions of usual injuries, and typical points of contact.

The fatality surveillance effort will be expanded, in collaboration with the state Bureau of Public Health's Project FACE, to include on-site investigations of selected cases.[14]

College courses. Continuing education students in farm short courses are participating in hazard recognition, identification, and control field exercises using standardized inspection protocols. Agricultural college curriculums for agricultural engineering undergraduate and graduate degree program students have more agricultural occupational health promotion topics incorporated into required coursework.

Student work books and instructor training aids have been developed that facilitate the integration of agricultural hazard correction into existing design courses and other curriculum in the UW College of Agriculture and Life Sciences.

Comment

Physicians have important roles to play in the control of farm injuries and illnesses. Brief physician counseling that is focussed on a few hazards can be an effective injury control strategy.[10] Routine care visits made by agricultural workers or farm residents offer the clinician an excellent opportunity to encourage hazard control.

Physicians can point out that "always being careful" when doing dangerous work is no substitute for permanently

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Fatalities involving machinery in all US industries, 1980-1985.

Machine type		Frequency	Percent
agricultural tractors		1523	30%
other agricultural machines		693	14%
auger/elevator	(61)		
combine	(53)		
hay Baler	(42)		
brush hog/mower	(40)		
loader/skidder	(37)		
corn picker	(26)		
other	(434)		
mining and earth drilling machines		467	9%
earthmoving and excavating machines		458	9%
bulldozers	(108)		
other	(350)		
forklifts		318	6%
cranes		288	6%
presses, lathes and metal working machines		88	2%
woodworking machines		47	1%
other machines		1179	23%
Total		5061	100%

Source: Etherton J, Meyers J, Jensen R, et al. Agricultural machine-related deaths. *Am J Public Health*.1991;81:766-768.

removing dangers from the workplace whenever possible. Physicians can emphasize that the recognition, identification and control of hazards actually saves more lives and limbs than just "being careful" and is the preferred approach to injury control.

Physician counseling efforts with farm spouses have special prevention value since these individuals often assume responsibility for farm family health considerations and they have unique capabilities for encouraging cooperation. Physicians can also encourage hazard correction by using arguments about the need for protecting children against injury when addressing either parent from farm families.

Physicians can describe typical examples of hazard correction and encourage farmers to plan and implement a comprehensive program of maintenance and prevention. For example:

- ensure that machine guards are in place over exposed moving parts on all farm implements;
- check and repair traffic indicators on all farm equipment driven or towed on public roads; and
- install roll-over protection cabs or bars on all tractors, especially tractors with narrow front ends.

Acknowledgment

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Physician-Citizen of the Year nomination letter

Two years ago, the SMS opened to the public the nomiation process for its Physician-Citizen of the Year award. The result was an overwhelming outpouring of admiration and affection for Wisconsin's physicians. As a service to the members of the SMS, the *WMJ* is sharing some of these nominating letters with its readers.

The letters are edited only for length and the removal of personal names. The letters reprinted are not necessarily the nominations of the winning physicians.

Dr _____ is not only a very excellent and dedicated physician, he is also very dedicated and willing to give his spare time to many community activities that help many area children and adults. He is active in cross country skiing, donating time to the areas (ski league) helping children get interested in the health and fun sport of cross country skiing. He was also a very active president of the (ski club) that promotes skiing and helps junior and senior high school students.

In 1990 my son qualified for the Junior Olympic Cross Country Ski Team, which spent a week in Colorado competing with other Junior National Teams from all over the continental US and Alaska. (He) could not have gone if it were not for a fund raising drive that Dr ____ headed.

Dr _____ is also very helpful in a student shadowing program that allows College Students interested in a possible Medical career, get work oriented experience by spending time with him which helps them very much in making decisions about the future.

Dr ____ is full of encouragement and enthusiasm and is a very positive role model not only for thechildren of our community but everybody he comes in contact with.

Teens seek answers about AIDS and HIV at SMS Workshop on Health

Shari Hamilton, assistant editor

How do you induce hundreds of middle school students to consider adopting behaviors that can reduce their risk of contracting AIDS or HIV? Give them the chance to meet, face-to-face, a young mother who is dealing with the daily realities of the illness. Introduce them to students like themselves who have assumed responsibility for learning the facts about HIV. Give them an open forum to question physicians about myths and real-life risks. Then, follow it all up with a lively motivational speaker offering a strong message about "owning your choices."

That was the strategy employed by the SMS and its auxiliary's 30th Teen Workshop on Health. More than 1,000 middle school students from across Wisconsin gathered in Green Lake and Eau Claire in early November. The auxiliary's goal in organizing the workshop, according to Colleen O'Connor, auxiliary health promotions chair and conference facilitator, was to encourage students to take a closer look at AIDS and HIV, and discuss the choices they will make that may affect their future health.

Looking at an auditorium jammed with hundreds of bright young faces, AIDS seems like a dark, unknown terror stalking the nursery door. The crushing reality is that more Wisconsin families will lose family members to this disease unless greater attention is paid to increasing awareness of the behaviors that can result in AIDS infection.

Getting good information

With the goal of awareness in mind, the auxiliary brought forward a slate of speakers aimed at capturing the minds of middle school students long enough to impart a message of health and safety.

In his welcoming words to students, SMS President William J. Listwan, MD, noted that adults are not always comfort-

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able talking to the younger generation about sex. "That's why the medical society sponsors this workshop. We don't want you to have to guess when you are making choices that affect your future health," Dr Listwan said. "We want you to have the chance to ask real doctors the questions you may have about AIDS and HIV."

Dealing with HIV

Not surprisingly, few students seemed inclined during the early minutes of the workshop to ask questions, preferring to just sit back and wait for things to happen. The students soon warmed up, however, when a trio of teen performers took the stage. The group, called JABONGGIT for Just a Bunch of Ordinary Guys and Girls in Theater, captured their interest with an interactive skit that taught students how to mimic the sounds of rain. Soon the conference center was awash in the sounds of raindrops, wind and foot-stomping, crashing thunder.

Capitalizing on the gains made in drawing audience attention, the drama group moved quickly into a vignette. On stage, a young female performer confided to her girlfriend her newly discovered attraction for a certain young man. As they spoke, the guy in question passed by.

"You mean his condition doesn't bother you?" the friend asked incredulously.

"What condition?" the first girl queried.

"He's got HIV," was the answer.

The actors then turned to the audience and asked students to share their reactions to the emotions tapped by the skit. The students eagerly responded.

In their interactions with the audience, the young actors demonstrated a strong basic understanding of HIV and AIDS, and relayed the message to youth that each person-from teenagers to adults--is responsible for becoming educated on this topic.

Making a commitment to health

By the time University of Wisconsin physicians Paul Grossberg, MD, (in Green Lake) and Frank Graziano, MD, PhD, (in Eau Claire) took up the topic of "Sex, Drugs and HIV: It Can't Happen to Me... Can it?," students were comfortable with going to the microphones, and were quick to pose questions. The physicians explained how the virus is transmitted and encouraged students to discuss things they had heard about HIV and AIDS so they could dispel myths about the disease.

The doctors candidly discussed behaviors that can increase or decrease a person's risk, and showed students slides diagramming the proper way to put on a condom. They talked about the failure rate of methods of so-called "safe sex."

Education about AIDS is not enough to keep someone from infection, the physi-

Continued on page 692

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Continued from page 690
cians stressed, each person must make a commitment to living a healthy lifestyle.

"He (the physician) helped me see the seriousness of the disease and the reality that it could happen to me or someone like me," one student noted in his evaluation.

Other students wrote:

"He made me realize that AIDS or HIV is best (avoided) with abstinence. He also gave me a good concept of the growing number of cases."

"It really opened my eyes to what's out there."

"If you don't make the right choices, it can happen to you."

But she looks so normal

Many of the students had never to their knowledge met anyone infected with HIV. At the Workshop on Health, Tammy Pheasant, a 24-year-old mother of one, described the experience of living with HIV.

As the students watched, Pheasant unpacked the myriad medications she must take each day to maintain her health. She talked about the pain and problems; the effect the disease has had on her life and her toddler daughter; and her inability to believe that she is going to die–even after being infected with HIV for 8 years.

The students lost no time in unabashedly quizzing Pheasant about her life–and no question seemed too bold. How did you become infected? How long have you known? What did you do when you found out? How does it feel to know you are going to die? What's going to happen to your daughter? And, even, does your doctor say it's OK for you to smoke?

Wincing slightly when the questions struck too close to home, Pheasant answered each query. She described her lifestyle, driving home the point that she wishes she had now made healthier choices.

Student reactions to Pheasant's presentation fell closely in line. "She so brave," the evaluations stated over and over again.

Other comments:

"It's real life. It makes you think about what could happen to you."

"I knew that AIDS was serious, but now I know that it's a lot harder for people who have the AIDS virus."

"I thought her story was very sad. I think she is a very nice person and I wish her well."

"I had no idea how many drugs you have to take to lead a halfway normal life with HIV. It made me aware that abstaining from sex is really worth it in the long run."

Owning your choices

After more than 3 hours of discussion–some of it fairly heavy, some of it laced with laughter–students were ready to enjoy the antics of motivational speaker Bob Lenz. Projecting a strong message about "owning your choices," Lenz told tales on himself and relayed anecdotes about dear friends who chose to follow unhealthy paths. He urged students to learn from the actions of some of society's "heroes": Magic Johnson, Mike Tyson and others. Lenz stressed that these individuals were not "victims," but rather, people who chose behaviors with dangerous consequences.

Captivated by his clowning, the students laughed as Lenz drove his message home.

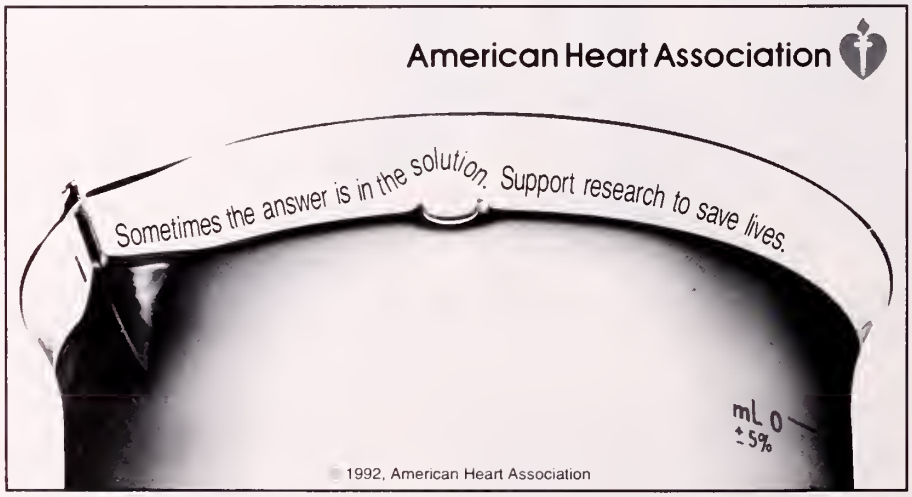
"I kind of am a drinker. When Bob was talking about the car accident, right away I did not want to drink anymore," one student wrote in her evaluation.

"He was very, very, very funny," commented another. "He got his point across without lecturing."

Laying the groundwork

Nearly all of the children who filled out the evaluations rated the workshop highly.

Returning to their schools, students from many areas will be asked to report on the workshop to their classmates. Some are planning group presentations; others will write articles for school newspapers. Most wrote that they also intend to share their newfound knowledge informally with friends. Regardless of how the message is passed, the 1992 Teen Workshop on Health has provided students with a seed for understanding the responsibility each has for maintaining his good health, and increased awareness of AIDS and HIV. Environment will determine just how well that seed grows.[15pt]



Giving health care a human face

A new program gives the public a peek at what it means to be a doctor

Cheryl McCollum, SMS field representative

A few months after I started working at the SMS, a physician walked into my office and, as he sat down, he looked at me working at my computer and said, "You know Cheryl, you will learn more about the field of medicine if you spend a couple of days with me in my practice than you will ever learn behind that computer."

A year later, I found out he was right.

Thanks to the mini-internship program, I was able to spend 2 days with four physicians and was able to get a first-hand experience on what it is like to be a physician. Those 2 days in two clinics and two hospitals gave me an insight into the life of physician that I could not have possibly experienced in working in my office or at county medical society meetings.

The mini-internship program I participated in was held in La Crosse County at both the Gundersen Clinic and Lutheran Hospital complex and the Skemp Clinic and St Francis Medical Center complex. It was the first mini-internship program held in the state, and was developed after the 1992 SMS House of Delegates passage of a resolution calling for implementation of a pilot mini-internship program before the 1993 SMS annual meeting.

The program is a chance for lay people to follow in the physician's footsteps and see the world as they see it. During office visits, hospital rounds, surgery, and emergency care, the interns share a doctor's busy schedule for 2 days. Participants in the La Crosse program included a local newspaper reporter, a hospital administrator, business leaders, and a local television anchor who produced a four-part series of her experience.

During the half day the intern spends with a physician, there is the opportunity for questions and conversation. The shared experience allows both to learn from each other.

During those 2 days, I was emotionally charged. Afterward, I could not stop thinking and talking about my experience, but I was also physically exhausted. My first day, I wore street shoes, the next day I *had* to wear tennis shoes. My feet and back ached after standing for a full day.

During my internship: I followed an internist as she did her rounds in the hospital; a radiologist showed me the various pieces of equipment he works with on a daily basis; an emergency room physician provided me with the insight on the craziness that goes on in his department; and a family physician explained to me the variety of patients she deals with day to day. Other interns in the program worked with a variety of physicians including a cardiac surgeon and a pediatrician.

The program helped me realize that physicians do more than read charts, take tests, and perform examinations. I was reminded that physicians have the "people" element to deal with every day.

I will never forget how one family physician held the hand of one of her patients as she broke down in tears when discussing her young son. Or the concern in the voice of an internist as she asked her patient if she will be able to take care of herself when she gets home from the hospital.

I also saw the real side of pain: the x-ray of a patient with a brain tumor; the broken leg of a woman as she rolled into the emergency room; and the look of fear in the eyes of

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"Ron's Rule—I give myself one week to meet new people and start having fun on a locum tenens assignment. It hasn't failed me yet."

Ron Richmond, MD, joined the CompHealth locum tenens medical staff when he completed his residency. He wanted to travel. He loves to meet people. A little time off sounded really good. And he thinks being exposed to different types of medical practice will serve him well when he returns to his hometown to establish a community health center.

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family members as they watched their loved ones being examined in the hospital.

I was initially concerned that patients would be uncomfortable with my presence in the room. But nearly every patient said "yes" when the physician asked them whether it was all right that an intern came into the room while they were examined. It was also helpful that I wore a white coat (I had not understood the power of the garment).

Through these personal experiences, the program created a greater understanding for me and the other interns of what physicians must face daily. With today's emphasis on cost containment and medical technology, the mini-internship program brought medicine back to the human level.

In La Crosse, the program was organized by Bruce Polender, MD, and Stephen Shultz, MD. Both agreed that the program was a success and look forward to holding two or three programs a year, including a program that will include their local legislators.

Members of the Racine, Milwaukee and Wood county medical societies, in conjunction with local auxiliaries, are also developing mini-internship programs. In July, the SMS Board of Directors authorized the creation of an ad hoc steering commission on mini-internships. Members include: Robert Phillips, MD, of Wood County (chair); John Beasley, MD, of Dane County; Mark Belknap, MD, of Ashland County; Carl Eisenberg, MD, of Milwaukee County; Terry Hankey, MD, of Waupaca County; Bruce Polender, MD, of La Crosse County; and Gregory Shove, MD, of Racine County.

Developed by the AMA, the mini-internship is a community relations tool that brings physicians and community leaders together in a one-on-one setting. For more information on the program contact your field representative at the SMS at (608) 257-6781 or, outside Madison, 1-800-362-9080.

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Madison physician joins global fight against pollution

Depletion of the stratospheric ozone, widespread water pollution, air pollution, and groundwater contamination are some of the pressing global pollution problems that prompted the United States' recent participation in the assembly of the International Society of Doctors for the Environment (ISDE), according to a Madison physician who served as the sole US delegate.

John K. Scott, MD, a Wisconsin otolaryngologist and past SMS president, traveled to Stockholm, Sweden, in late September to discuss the role physicians can play in addressing pollution problems posing a threat to the inhabitants of the Earth, current and future. ISDE is working to bring worldwide environmental health issues to the forefront of public concern.

Although the recent forum was the third assembly of ISDE, the United States had never before participated in the global environmental health discussion. But in 1992, Dr Scott said, the United States has declared an end to isolationism. The past chair of the AMA's Long Range Planning Council, which has been working with the Council of Scientific Affairs in matters of the environment, Dr Scott was asked to represent the newly organized National Association of Physicians for the Environment (NAPE) as its first delegate.

Still in fledgling stages, NAPE was founded earlier this year by John T. Grupenhoff, PhD, of Potomac, MD, with physicians Jerome C. Goldstein, MD, executive vice president of the American Academy of Otolaryngology-Head and Neck Surgery, Inc., and Peyton E. Weary, MD, chair of the department of dermatology at the University of Virginia in Arlington. Grupenhoff has worked as a consultant and representative of physicians groups for the last 20 years. He served, under the Johnson administration, as deputy assistant secretary for health and environmental legislation of the (then) Department of Health, Education and Welfare and worked on the nation's first major air quality legislation in 1967.

Since the organization was founded in January 1989, ISDE has grown to 7,000 physician members. The roster also includes dentists, veterinary surgeons, pharmacists and other health workers. Approximately 35 physicians attended the Stockholm meeting, representing 30 countries.

The aim of the international society is to inform and make the worldwide public aware of the problems linked with pollution produced by human activity to protect health and the continuity of life on the planet Earth. ISDE's mission also calls for members to fight against every type of environmental degradation of air, weather and the soil, both in the world and locally.

ISDE concerns are diverse. Members decry the lack of insight which has resulted in dying forests; poisoning of air, water and soil; destruction of the stratospheric ozone layer; development of the potentially negative greenhouse effect caused by industrial and automotive emissions; and extinction of thousands of species of animals and plants. Mankind must be considered, members urge, as only part of nature; the environment must be considered the basis of health and welfare. In an ongoing appeal to all doctors of the world, ISDE urges physicians to make the public aware of dangers and their causes exert influence within medical and sanitary associations; to gain the attention of administrators and politicians; and to search for new problem-solving procedures with the industrial and labor worlds and environmental organizations.

"There are no winners. We're all losers when it comes to pollution," Dr Scott said, stressing that problems with the ozone aren't limited to geographical borders. Production in the US corn belt is down 30% because of the ozone problem, and the destruction of the ozone layer will continue until chlorofloral carbons are eliminated, he said.

The contamination of the Great Lakes, which account for one fifth of the world's

John K. Scott, MD

fresh water supply, is a special concern for ISDE, according to Dr Scott. Many of the countries in the world are experiencing severe water pollution problems. For example, Dr Scott said, one third of the groundwater in Poland is unusable. "Germans have been working to clean up the Rhine River, but at great financial cost," he said.

Another notable concern is the continued use of cadmium in gold mining which results in kidney problems among residents living near the mines. Everyone must work together to eliminate this health hazard, Dr Scott said.

ISDE members are also troubled by predictions stemming from the sheer numbers of people; the Earth's population is expected to double in the next century. Dr Scott said scientists have reason to believe the second generation after the year 2001 will experience widespread environmental deterioration, causing–among other problems–starvation, and many people will die.

In developing solutions to problems with agricultural chemicals and contami-

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Continued from preceding page
nants, Dr Scott said physicians all over the world should take note of what is happening in Sweden. There, doctors and farmers are working closely to come up with solutions to environmental problems.

The next meeting of ISDE is scheduled to be held in Antwerp, Belgium, in October 1993. Meanwhile, Dr Scott and other ISDE leaders are preparing to launch a full-scale fight against pollution closer to home.

The US National Association of Physicians for the Environment (NAPE) will hold its first national conference February 23 and 24, in Washington, using a grant from the Institute of Environmental Health Sciences, a branch of the National Institute of Health. The program is slated to include discussion of environmental concerns by representatives of many medical specialty organizations, including: otolaryngology; allergy and immunology; family physicians; neurology; radiology; pediatrics; internal medicine; physical medicine; emergency physicians; ob-gyns; preventive medicine; surgeons; anesthesiologists and others. Vice President-Elect Albert Gore and US Sen Tom Harkin have also been invited to speak. For more information about the agenda, contact Dr John T. Grupenhoff, Suite 203, 6410 Rockledge Dr, Bethesda, MD, 20817; or telephone (310) 571-9790.[150th]

Physician briefs

An * indicates a member of the SMS.

Don Anderson, a fourth-year medical student at the University of Wisconsin Medical School, has been selected to serve as the AMA medical student representative on the Liaison Committee on Medical Education. Last year, Anderson served as chair of the AMA Medical Student Section Committee on Long-Range Planning.

Benjamin W. Begley, MD*, has joined the practice of Orthopaedic Associates of Oshkosh, SC. Dr Begley graduated from the Indiana University School of Medicine in 1987. He completed his orthopedic surgery residency program at the University of Wisconsin Hospital and Clinics in 1992.

Sean T. Benham, MD, has joined the staff of Manitowoc Clinic. A general surgeon, Dr Benham served his internship and residency at Providence Hospital in Southfield, Mich.

Joe Boero, MD*, is a new addition to the Marshfield Clinic-Park Falls staff. Dr Boero earned his medical degree from the University of Illinois College of Medicine, where he went on to join the faculty. Dr Boero specializes in internal medicine.

Ferdinand Cabrera, MD, has joined the medical staff of Victory Medical Center in Stanley. Dr Cabrera, an internist, completed his residency at Veterans Administration Hospital in San Juan, Puerto Rico in June 1992.

Mark J. Giovanelli, DO*, is a new member of the staff at Medford Clinic. Dr Giovanelli earned his degree at the College of Osteopathic Medicine and Surgery at Des Moines, Iowa, in 1973. He served an internship in Davenport, then began practicing general medicine in Milwaukee.

Ron Harms, MD*, has rejoined the Shawano Clinic on a full-time basis, resuming his family practice and expanding his sports medicine practice. Dr Harms will also be helping to establish an industrial medicine service in the Shawano area.

Russell J. Hermus, MD*, has joined the medical staff at Rhinelander Medical Center. Dr Hermus, a family physician, completed his residency at the University of Wisconsin-Madison in July 1992. He also earned his medical degree from UW.

Thomas G. Hoeft, DO, has joined the staff of Divine Savior Hospital in Portage. Dr Hoeft has relocated from O'Fallon, Ill, where he served as a major in the US Air Force Reserve. He was a general medical officer for the US Navy at the Naval Station Branch Clinic at Subic Bay in the Philippines. Dr Hoeft, a University of Wisconsin alumnus, is a graduate of the Kirksville College of Osteopathic Medicine.

Robert S. McDonald, MD*, has joined the staff of Mercy Medical Center in Oshkosh. Dr McDonald is a general, vascular and cardiothoracic surgeon. He earned his medical degree from the Medical College of Wisconsin in 1984. He completed a general surgery residency at Baylor College of Medicine in Houston; a cardiovascular fellowship at Massachusetts General Hospital; and a cardiothoracic surgery residency at the Medical College of Wisconsin.

Edwin L. Overholt, MD*, of La Crosse, has received the Laureate Award from the Wisconsin Chapter of the American College of Physicians. Dr Overholt is an internal medicine physician at Gunderson Clinic, Ltd. He has served as director of medical education for the Gunderson Medical Foundation since 1968.

John R. Reiskytl, MD*, a family physician in Random Lake, has completed all the requirements for certification by the American Board of Family Practice. Dr Reiskytl received his medical degree in 1988 from the Medical College of Wisconsin. He completed a residency at the Hinsdale Family Practice Residency Program in Illinois, where he was recipient of the program's 1991 Educational Award. [150th]

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The individuals and organizations named below made contributions to the Charitable, Educational and Scientific Foundation from September 1 - October 31, 1992.

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In recognition of those individuals, county medical societies and auxiliaries who contribute their support to this Fort Crawford Medical Museum.

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In Memoriam
In loving memory of those individuals who will grace our paths forever.

Louis Babby, MD
Catherine Beatty
Michael Belson, MD
William T. Brodhead, MD
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The individuals named below made contributions to the Charitable, Educational and Scientific Foundation through the SMS membership dues statement from September 1, 1992 - October 31, 1992.

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William G. Weber, MD
Edward R. Winga, MD
Margaret C. Winston, MD[150th]

County society news

Ashland-Bayfield-Iron. The Ashland-Bayfield-Iron County Medical Society elected the following physicians into membership Sept 24, 1992: John Schultz, MD; Andrew Matheus, MD; Kevin McClelland, MD; and Richard Searl, MD.

Brown. The Brown County Medical Society accepted the following physicians into membership: Kishore Pathial, MD; James Warpinski, MD; Daniel Gutenberger, MD; Steven Bollom, MD; Steven Weinshel, MD; Sayuri Pearson, MD; Steven Mayo, MD; and Jaswinder Sundlass, MD; Moon Yun, MD; Lucy Edrozo, MD; Jonathan Thomas, MD; Marie Nassiff, MD; Lawrence Reich, MD: J. Dewey Cooper, MD; Scott Escher, MD; and Kevin Hart, MD.

Grant. Dr Raymond Sloan has been approved for transfer of his membership to Grant County from Oneida County. Officers for the upcoming year will be Meenakshi Maski, MD, president; Kevin Carr, MD, vice president; William Fast, MD, secretary/treasurer; Kurt Wilhelm II MD, SMS delegate; and C.E. Mueller, MD, alternate delegate.

Kenosha. New members of the Kenosha County Medical Society are: Norman K. Weinstein, MD; Mary B. Barr, MD; Mark J. Witeck, MD; Veronica G. Carver, MD; Carolyn G. Newton, MD; Jerome R. Sheff, MD; Wahab A. Kazi, MD; Elizabeth J. Devaney, MD; Mohammad S. Khan, MD; and Walter Wong, MD.

Oconto. Dr Douglas C. Gremban was elected to membership in the Oconto County Medical Society at its October meeting.

Outagamie. Stephen J. Marquis, MD, was approved for membership in the Outagamie County Medical Society.

Ozaukee. At the Sept 24, 1992, meeting of the Ozaukee County Medical Society, the following physicians were approved for membership: Tracy Bretl, DO; Martha Jay, MD; Steven Kulick, MD; and Joseph Schwartz, MD.

Sheboygan. The Sheboygan County Medical Society elected the following physicians to membership at its Sept 30, 1992 meeting: Jesse Cheng, MD; Jeane-Marie Valicenti, MD; and Shahla Durrani, MD.

Vernon. The Vernon County Medical Society met Nov 10, 1992. The featured scientific speaker was Dr Richard Cardillo, pulmonologist from Luther Hospital of Eau Claire and affiliate of the Mayo Clinic, spoke on pulmonary infections in the elderly. Members and guests who are interested in attending the next meeting should contact the society president, Dr Mark Andrew at 608-637-3195 or the society secretary/treasurer, Dr Rolando A. Macasaet at 608-637-3174. The county society expects to have another scientific or educational speaker and election of new officers at its next meeting.

Walworth. Elected to membership in the Walworth County Medical Society are David Mahon, MD; and Orest Mryszuk, MD.

Waukesha. Kristine M. Klewin, MD, has been accepted into membership in the Waukesha County Medical Society.

Winnebago. The Winnebago County Medical Society has elected the following physicians to membership: Robert Bernstein, MD; Tiffany Corrigan, MD; Jeanette Salone, MD; William Kasper, MD; Teresa Shoberg, MD; Patricia Kasper, MD; Thomas Tolly, MD; David Burch, MD; Alfred Wankel, MD; Robert McDonald, MD; and Patrick O'Brian, MD.[150th]

Obituaries

Michael J. Belson, MD, of Green Bay, died Sept 20, 1992, at the age of 57. He was born Dec 11, 1934, in Manitowoc. Dr Belson graduated from Marquette School of Medicine in 1960 and completed his ophthalmology residency at Presbyterian-St Luke's Hospital in Chicago. He served in the US Army from 1966 to 1968. He was one of the founding physicians of the Eye and Ear Associates Clinic in Green Bay, as well as a member of the AMA, American Board of Ophthalmologists, Royal Society of Medicine, and the SMS. He is survived by four sons, Dr Brian Belson, of Oklahoma City, Michael Belson, of Iowa Falls, Idaho, Patrick Belson, of Des Moines, Iowa, and Christopher Belson, of Milwaukee; two daughters, Bridget Belson, of Janesville, Maureen Belson, of Iola; two grandchildren; his mother, Lucille Belson, of Manitowoc, and two sisters.

Clement F. Cheli, MD, of Columbus, died Monday, Oct 5, 1992, in Wyocena. He was born Nov 2, 1902, in Calumet, Mich. A resident of Columbus for the past 60 years, he graduated from the University of Wisconsin and the UW Medical School. He was a member of the AMA and the SMS.

Dr Cheli was a general practitioner and chief of staff at Columbus Community Hospital. He was also a regional health officer. Surviving are his three daughters, Nancy Andrews of Milwaukee, Lucia "Patti" Reagan of Madison, and Jeanne Meiller of Madison; ten grandchildren and a great-granddaughter.

Mark W. Garry, MD, of Milwaukee, died Aug 10, 1992. Dr Garry was born Aug 8, 1906, in Manawa. He received his medical degree in 1934 from the Marquette University School of Medicine and completed his internship at St Elizabeth Hospital in Appleton. Dr Garry was the chief of internal medicine at Veteran's Hospital for many years. He is a former director of student health services at Marquette University and was associated with the Bluemound Medical Clinic for many years. Dr Garry was a member of the Medical Society of Milwaukee County, American College of Physicians (fellow), Milwaukee Academy of Medicine, American Federation for Clinical Research, American Thoracic Society, American Society for Gastrointestinal Endoscopy, American Rheumatism Association, the SMS and the AMA. Surviving are his widow, Mary, and his children: Mark of Phoenix; Nellyann McGarry, of Bourbonnais, Ill; Mary Margaret Peller, of Waukesha; Kathleen Flynn, of Milwaukee; and Nora Mace, of Shorewood. He was preceded in death by a son, Joseph, of Poy Sippi. Also surviving are 18 grandchildren and 10 great-grandchildren.

Douglas Hatchfeld, MD, Oshkosh, died July 5, 1992. He was born Nov 8, 1952, in Faribault, Minn, and graduated from the University of Minnesota Medical School in 1979. He completed his residency at the Winnebago Mental Health Institute, specializing in psychiatry. He was a member of the SMS. Dr Hatchfeld is survived by his wife, Karen.

Hugh A. Johnson, MD, died July 21, 1992. He was formerly a plastic surgeon on the staff of Northwoods Hospital in Phelps. He also did volunteer work in Russia, Vietnam, India and other places throughout the world. Surviving is his wife, Madeleine, two daughters, Cynthia Whealler and Madeleine Saravalle, and one son, Daniel.

Tributes to loved ones can help others

The memorial program of the Charitable, Educational and Scientific Foundation of the SMS offers physicians a unique opportunity to provide a living memorial to a loved one or friend through a gift to the foundation. A memorial contribution can provide financial aid to a needy medical student, help stimulate research on behalf of the public health or aid in the preservation of Wisconsin's medical history. When a memorial gift is made to the foundation, the deceased person's family receives a special card with the name of the donor. For more information, contact the foundation staff at the SMS.[150th]

Josef A. Kindwall, MD, of Milwaukee, died July 29, 1992. He was born Feb 4, 1895, and received his medical degree from Johns Hopkins University in 1927. He interned in Rochester, NY, and completed his residency at White Plains, NY, specializing in psychiatry. Dr Kindwall was a member of the American Psychiatric Association, Central Neuro-Psychiatric Society, Milwaukee Neuro-Psychiatric Society, Milwaukee Academy of Medicine, Milwaukee Psychiatric Hospital, the SMS and the AMA. He is survived by his son, Dr Eric Kindwall of Milwaukee.

John P. Malec, MD, of Madison, died Aug 2, 1992, in a local nursing home. He was born on July 11, 1909, in Madison and graduated from the University of Wisconsin Medical School in 1934. He served a rotating internship in St Luke's Hospital in Duluth, Minn, in 1934-1935. His surgical residency took place at Strong Memorial Hospital, in Rochester, NY, and at UW Hospital. He was an instructor of surgery at the UW Hospital and a clinical assistant professor of surgery. He served in the US Army Air Force as an assistant chief and chief of surgery as a lieutenant colonel in the US Marines from 1941 to 1946. He was in private practice surgery in Madison since 1946. He was co-founder of Associated Physicians, and was a member of the American Board of Surgery, American College of Surgeons, and American Medical Society, as well as chief of surgery at Madison General Hospital. Surviving are his wife, Louise; a son, John Malec, Jr; five grandchildren; and a sister.

Arthur G. Norris, MD, of Wauwatosa, died Sept 12, 1992, at the age of 54. He served as medical director of Milwaukee Psychiatric Hospital from 1982 to 1991. He taught at the Medical College of Wisconsin as an associate clinical professor and served on committees of the SMS and the Medical Society of Milwaukee County. Dr Norris graduated from the University of Wisconsin Medical School in 1965. A native of Altoona, Penn, he received a bachelor's degree from Juniata College in Huntingdon, Penn, and a doctorate from Johns Hopkins University in Baltimore. He was past president of the Milwaukee Neuro-Psychiatric Society and the Milwaukee Chapter of the Wisconsin psychiatric Association. He is survived by his wife, JoAnn Norris; a daughter, Madeline Norris; a son, Christofer Case; his father, Glenn Norris of Martinsburg, Penn; and three brothers.

Theodore M. Paulbeck, MD, of Elm Grove, died Oct 5, 1992, at the age of 87. Dr Paulbeck graduated from Marquette Medical School in 1933 and the University of Pennsylvania Graduate School of Medicine in 1945. He was an honorary member of the department of surgery, section of general surgery, at St Joseph's Hospital. He was a member of the AMA, SMS, American Board of Abdominal Surgery and was appointed a Fellow of the International College of Surgeons in 1965. Dr Paulbeck is survived by his wife, Helen; his children, Penny Feerick of Delafield, Teddy of Denver, and Pamela

Continued on next page

Continued from preceding page
Blons of Wilmette, Illinois; a sister; nine grandchildren and three great-grandchildren.

Margaret "Jo" Prouty, MD, a Madison pediatrician died Aug 28, 1992, in Madison. Dr Prouty was born in London Mills, Ill, on Aug 12, 1908. She was a graduate of the University of Nebraska Medical School in 1942 and interned at Norwegian American Hospital in Chicago. She joined the Jackson Clinic in Pediatrics in 1943 and remained until her retirement in 1973. She was honored for her 50 years of medicine by the SMS in May of this year. Dr Prouty was a member of the Altrusa Club of Madison and supported the Well Baby Clinic and the Visiting Nurses Association. She wrote five sections on hiking for the International Encyclopedia of Sports Medicine. She is survived by her sister-in-law, Margaret Ann Prouty of Hartford, of Connecticut; a nephew and his wife; and several grandnieces and their families.

Emilio B. Regala, Jr, MD, of Hartford, died Sept 29, 1992, at the age of 59. He was born August 4, 1933, in Manila, Philippines. He came to the United States in 1957, settling in New Haven, Conn, and moved to Hartford in 1976 where he was an internist at the Hartford Parkview Clinic. He attended the University of Philippines High School and the University of Philippines Pre-Med in medicine. He then served his residency at St Raphael Hospital in New Haven, the Albert Einstein Hospital in Bronx, NY, and the Alexian Brothers Washington University in St Louis, Mo. Dr Regala was a member of the SMS and president of the Washington County Medical Society. Survivors include his wife, Leticia; five sons, Emmanual of St Paul, Benjamin of Okinawa, Philip of Miami, Emilio of Hartford, and Christopher of Madison; a daughter, Rebecca Regala of Milwaukee; two sisters and his father, Emilio of the the Philippines.

Donald J. Ryan, MD, of Ephraim, died Aug 30, 1992, in Ephraim. Dr Ryan was born in Syracuse and received his doctor of medicine degree from Syracuse University College of Medicine in 1947. He interned at Detroit Receiving Hospital and completed his radiology residency at Grace Hospital in Detroit in 1951. He was a captain in the US Air Force until beginning his practice in Neenah in April 1953 with Dr S.R. Beatty, later under the name of Radiology Associates of the Fox Valley. Dr Ryan retired to Ephraim in 1983. He was a member of the medical staff of Sturgeon Bay Memorial Hospital, the Radiological Society of North America, the SMS, and the AMA. He was a diplomate of the American Board of Radiology and a fellow of the American College of Radiology. He served as president of the medical staff of the Theda Clark Regional Medical Center in Neenah, Mercy Medical Center in Oshkosh and the Winnebago County Medical Society. Surviving are his widow, Billie; children Donna Jo (N.G.) Nickolas of Neenah, Kathleen Ryan of West Chazy, NY, Elizabeth Ryan of Indianapolis, Brooke Odegard of the Netherlands and Kirk Ryan of Chicago; and 11 grandchildren.

Lynn J. Seward, MD, of Berlin, died Aug 10, 1992, in Berlin. Dr Seward was born Aug 17, 1906, in Fort Pierre, SD. He graduated from the University of Rochester, NY, where he interned. He was an assistant to Dr Libby Pulsifer of Rochester for 1 year, in general practice. He moved to Berlin in 1935, where he practiced medicine. Dr Seward was a member of the US Army Corps in World War II and served 38 months in the European Theatre. Following his discharge from the service, he studied at UW-Madison and White Memorial Hospital in California before resuming his practice in Berlin in 1951. He was a member of the AMA. Surviving are is widow, Gladys; daughter Janet Jaecks of Lincoln, Neb; son Dr Robert Seward of Des Moines, Iowa; six grandchildren; and two sisters.

James David Storey, MD, of Lee Township, died Sept 17, 1992. He was born Oct 29, 1939, in Butler, Penn, and received his medical degree in 1965 from the University of Pittsburgh, where he also completed his internship and residency, specializing in pathology. He served as chief of clinical chemistry at St Luke's Medical Center for 9 years, then held a similar position at the veterans hospital from 1981 through 1989. He also taught for 20 years at the Medical College of Wisconsin, including an 8-year stint in the 1980s when he held a full-time teaching load. He was a 30-year member of the US Navy Reserves and held the rank of captain. Surviving is his wife, Betty; mother Maxine Storey; daughter Laura Storey; son David Storey; brother, aunt, uncle, and great-uncle.

Alan Taber, MD, former chief of staff at Berlin Memorial Hospital, died July 23, 1992; in the Chicago area. He was born Aug 11, 1951; in New York and received his degree from Northwestern University. He served his internship at Grant Hospital of Chicago and his residency at the University of Minnesota-St Johns. He was a member of the AMA and SMS.

Gerald W. Wadina, MD, of West Allis, died Sept 1, 1992. Dr Wadina practiced in Cudahy for 23 years and was on the staff at Trinity Memorial Hosptial where he was past chair of the department of surgery, the Audit Committee and Quality Assurance Committee. He was also on the staff of St Francis Hospital. He was appointed associate clinical professor of ophthalmology at the Medical College of Wisconsin and was a member of the Milwaukee County Medical Complex Eye Institute. He was also a member and past president of the Milwaukee Ophthalmological Society, Board of Ophthalmology, AMA, SMS and Medical Society of Milwaukee County. Surviving are his wife, Sherry; two sons, Derek and Curt; his parents and a brother.

Index to articles: 1992

Key to numbering. The first number is the issue number (eg, January is 1, February is 2, etc). The second number is the page number. The numbering of pages are continuous beginning with the January issue. All issues are Vol 91.

Authors of scientific articles

(All authors are MDs unless otherwise noted.)

Alvarez, John D., San Antonio:8-480
Anderson, William, Wauwatosa:9-533

Bahr, G. Richard (non-MD), Milwaukee:6-291
Bastin, Kenneth T., Madison:7-343
Bauwens, Steven F. (non-MD), Chesapeake, Va:6-299
Benzer, David G. (non-MD), Wauwatosa:9-533
Bernstein, Barry M., Milwaukee:6-291
Broekhuizen, Fredrik, Waukesha:6-296

Cannon, Todd, Milwaukee:9-530
Capasso, Charles, Neenah:10-577, 581
Cassanova, James E., Milwaukee:2-73
Chusid, Michael J., Milwaukee:2-73
Cogbill, Thomas H., LaCrosse:9-527
Corsten, Luke (non-MD),Milwaukee:3-125

D'Cruz, O'Neill F., Milwaukee:3-130
DeLano, Cynthia, La Crosse:2-67
DeSmet, Arthur A., Madison:6-299
Donegan, William L., Milwaukee:3-125
Drinka, Paul J., Madison:6-299

Gillis, Rick D., Milwaukee:2-73
Glasser, Karen E.(non-MD), La Crosse:2-67
Greist, John H., Madison:4-169

Hansen, Kurt, Madison:7-348
Harms, Ron L., Shawano:4-173
Hardie, Robert C., Milwaukee:11-627
Harms, Ron L., Shawano:4-173
Harned, Lewis B., Madison:8-480
Harrington, J.T., Madison:10-579, 585

Idarraga, Samuel, Marshfield:10-577

Kelly, Jeffrey A. (non-MD), Milwaukee:6-291

Landercasper, Jeffrey, LaCrosse:9-527
Lawton, John M., Green Bay:5-214
Lee, Yeu-Tsu Margaret, Honolulu:8-480
Livengood, Larry, Appleton:10-583

Mayersak, J.S., Wausau:11-629
Mehta, Minesh P., Madison:7-343
Morgan, Michael (non-MD), Milwaukee:6-291
Murphy, Debra A.(non-MD), Milwaukee:6-291

Oechler, Herbert W., Milwaukee:2-71

Quinn, Annette O'Leary (non-MD), Waukesha:6-296

Remington, Patrick L., Madison:7-348
Rothfusz, Ronald R., Marshfield:5-211

Schellpfeffer, Michael A., Kenosha:8-482
Shapiro, Sander S., Madison:8-482
Silva, Paul D., La Crosse:2-67
Sperry, Len, Milwaukee:9-530
Strutt, Pamela J. (non-MD), LaCrosse:9-527
Stueland, Dean, Marshfield:5-211
Sturino, Kathy (Waukesha):6-296
Suduikis, Sandra V., Milwaukee:3-125

Van Mullem, Chris (non-MD), Waukesha:6-296
Viviano, Carl J., Wausau:11-629

Walsh, David J., Milwaukee:3-130
Werlin, Steven L., Milwaukee:2-71
Wilson, Janet A., Wisconsin Rapids:8-480
Wittmaack, Frank M., Madison:8-477

Zimmerman, Janet M. (non-MD), Madison:7-351

Authors of non-scientific articles

(All authors are MDs unless otherwise noted.)

Anderson, Henry, Madison:1-43

Chapman, Larry J. (non-MD), Madison:12-685
Chudy, Nancy, Madison:11-633
Chybowski, Timothy J., Madison:8-485
Cosgrove, Amanda (non-MD), Kenosha:6-280

Defo, Barthelemy Kuate (non-MD),Madison:10-597

Fullin, Kevin J., Kenosha:6-280

Geis, Cecilia, Madison:10-591
Goldring, Jay (non-MD), Madison:5-240

Hamilton, Shari (non-MD), Madison:5-245,6-279,9-541,12-681,12-689
Hanrahan, Larence P. (non-MD), Madison:1-43
Haskins, Linda (non-MD),Madison:1-43
Higgins, Dee (non-MD),Madison:1-43

Jochimsen, Elise M., Madison:9-537

Kane, Richard S., Milwaukee:5-235

Lantz, Paula M.(non-MD), Madison:10-597

MacDonald, Frank M., Bayfield:2-88
Morris, Robert D., Milwaukee:5-240

Pezzino, Gianfranco, Madison:4-192
Phillips, Jerri Linn, Madison:9-537

Remington, Patrick L.,Madison:4-183,6-303,9-537,10-597,11-633

Sautter, Richard D.,Marshfield:1-49,5-250
Schiedermayer, David L.,Milwaukee:4-179
Schlenker, Thomas L.,Milwaukee:3-133
Schuler, Ronald (non-MD), Madison:12-685
Skjolaas, Cheryl A., (non-MD), Madison:12-685
Sleath, Betsy (non-MD), Madison:6-303

Tesch, Bonnie J.,Milwaukee:4-179

Vasudevan, Sridhar V., Milwaukee:10-589, 595

Wencel, Sally (non-MD),Madison:2-75
Wetter, David W.(non-MD),Madison:4-183
Wilkinson, Terry L., (non-MD), Madison:12-685
Worcester, Nancy (non-MD), Madison:6-284

Yoast, Richard, Madison:11-633

Scientific articles, abstracts and information

Adolescent suicide: an analysis using Erickson's developmental framework (Zimmerman) (Graduate nursing student writing contest winner):7-351
Adrenal insufficiency: hemodynamic and echocardiographic characteristics, Acute (Lawton):5-214
Antidepressant medication and suicide (Greist,Jefferson):4-169
Aortic calcification, and bone density, Lack of correlation between (Drinka, Bauwens, DeSmet):6-299
Addiction, Levels of physician responsibility in diagnosis and treatment of, Special (Benzer, Anderson):9-533
Alcohol consumption, the effect on body weight among Wisconsin adults (Hansen, Remington)(Student writing contest winner):7-348
Blood-borne pathogens: An overview of OSHA standards and an exposure control plan:5-219
Breast reconstruction, Patient satisfaction (Corsten, Suduikis,Donegan):3-125
-A comment on breast reconstruction (letters)(Loewenstein):5-210
Centenarians, Surgical procedures in (Cogbill, Strutt, Landercasper):9-527
Cocaine use, A multi-institutional analysis of perinatal (Quinn, Van Mullem, Sturino, Broekhuizen):6-296
Desert Storm, Operation: clinical experiences at the 13th Evacuation Hospital, a Wisconsin National Guard unit (Lee,Alvarez,Wilson,Harned):8-480
Echocardiographic characteristics, Acute adrenal insufficiency:hemodynamic and (Lawton):5-214
Esophagitis in an immunocompetent boy, Herpetic (Chusid,Oechler,Werlin):2-71
Fibromuscular pain disorders in the injured worker: accurate examination is the key to diagnosis (Harrington):10-585
Heterotopic pregnancy, A spontaneous combined: a case report (Schellpfeffer):8-482
Hip dislocation in a rural emergency department, Posterior (Stueland,Rothfusz):5-211
HIV-Infected patients, A needs assessment survey of (Murphy,Bahr,Kelly,Bernstein,Morgan):6-291
Lung cancer mortality in Wisconsin: year 2001 (Bastin, Mehta)(Resident writing contest winner):7-343
Magnetic resonance appearance of a rare intradural chordoma (Hardie):11-627
Migraine: case series and review of literature, Acute confusional (D'Cruz, Walsh):3-130
Midwifery in Wisconsin, The history and current status of nurse-(Glasser,DeLano,Silva,):2-67
Musculoskeletal pain and work disability (Harrington):10-579
Neck pain, Management of, (Idarraga):10-577
Neuroleptic malignant syndrome in a patient with neurosyphilis (Cannon, Sperry):9:530
Occupational low back pain: prevention of chronic disability (Capasso):10-581
Occupational soft tissue disorders of the hand and forearm (Livengood):10-583
Pain and disability, A report of the SMS ad hoc committee (Capasso):10-577
Physicians, pinstripes, and prevention: Wisconsin data (Cassanova, Gillis):2-73
Semen quality in Wisconsin men over one decade, Longitudinal study of (Wittmaack,Shapiro):8-477
Unilateral seminal vesicle cyst presenting as hematospermia: diagnosis established by transrectal prostatic ultrasound (Mayersak, Viviano):11-629
Wrestling minimum weight project, Wisconsin (Harms):4-173

Socioeconomic and ancillary articles

Abdominal surgery: Nicholas Senn, MD, 1844-1908, The great master of (Hamilton):5-245
Americans with Disability Acts, The (Wencel):2-75
Breast cancer survival in Wisconsin (Public Health) (Lantz, Remington, Defo):10-597
Cigarette smoking in Wisconsin, The increasing health and economic burden from (Public Health)(Chudy, Remington, Yoast):11-636
Disability acts, The Americans with (Wencel):2-75
Disability status, Assessment of: the role of the physician (Vasudevan):10-589
Domestic violence: an overview (Hamilton):6-279
-Empowering physicians to respond to domestic violence (Fullin, Cosgrove):6-280
-The role of health care workers in responding to battered women (Worcester):6-284
-Wisconsin domestic abuse programs, by county
-Resources for learning more about domestic violence:6-290
-Wisconsin's deadly secret-domestic violence (President's

page)(Listwan):6-263
Health care financing crisis in Wisconsin, The status of the (President's page)(Hetsko):3-115
–SMS members delve into the health care reform debates:3-155
–Health care financing reform in Wisconsin: Prescription for the future:4-163
Heart disease mortality, Policy implications of increased (Public health)(MacDonald):2-88
HIV-infected health care workers, SMS Board of Directors adopts new guidelines on:2-95
Journal manuscript resubmissions, Sample cover letter for (Soundings):1-7
Lead poisoning, A rationale for universal screening for childhood (public health)(Schlenker):3-133
Legislative wrap-up:1991-1992:6-305
Letters:1-8,2-64,3-120,4-166,5-210,6-272,7-337,7-338,8-470,8-471,9-520,9-521,11-622,11-624,12-670,12-671
–WIPRO called an "evil system"(Fogarty):1-8
–Don't shoot me, I'm just the doctor (Dickman):2-64
–Praise for the president's page (Hudson):3-120
–WIPRO and the justification of existence (Mayersak):3-120
–Cholecysto-sternal fistula (Falk):4-166
–A comment on breast reconstruction (Loewenstein):5-210
–An historic opportunity for health care reform (Koons):6-272
–Taking a stand against smoking (Burstein):6-272
–Minnesota's HealthRight not necessarily a disaster (Lancer):7-337
–Kudos from afar (Rubin):7-338
–Private practice is still the best practice (Fisher):8-470
–Founding principles need rediscovering (Fogarty):8-470
–How do you know when you have enough doctors? (Peterson):8-471
–National health care won't cure social ills (Downing):8-471
–Whither medicine? (Cameron):9-520
–Two objections to Adams' opinion (MacGorman):9-521
–Adams offered us excellent advice (Nichols):9-521
–This shouldn't happen here (Cameron):11-622
–Interfering in the patient-physician relationship (Andres):11-624
–Name game (Hacker):11-624
–Awareness helps (Owen, Wood):12-671
Medical Assistance to offer prenatal care coordination as benefit:11-636
Medical Care system, A moral response to the problems (Soundings)(Whaley):3-123
Medicare RBRVS, 150 years of SMS; enter (President's page)(Hetsko):1-3
–Medicare claims review, Budget cuts affect:1-42
–Understanding the Medicare fee schedule disclosure:1-22
Medical schools, The challenge to(President's page) (Hetsko):2-59
National health care funding system, A call for a (Soundings):6-273
OSHA standards and an exposure control plan, Blood-borne pathogens: An overview of:5-219
Occupational healthcare in agriculture at the University of Wisconsin-Madison, Promoting (Public health) (Chapman, Schuler, Wilkinson, Skjolaas):12-685
Occupational injuries, Project FACE: Wisconsin surveillance of fatal(Public Health) (Hanrahan,Higgins,Haskins, Anderson):1-43
Ozone in Wisconsin: potential health effects, Ground-level(Public health)(Goldring,Morris):5-240
Physician burnout, Primary care: definitions, self-assessment and treatment (Schiedermayer,Tesch):4-179
Physician citizen of the year nomination letter:12-688
Policy implications of increased heart disease mortality (Public health)(MacDonald):2-88
Prostate cancer in Wisconsin, 1980-1990, Increasing incidence of (Public Health) (Jochimsen, Remington, Phillips):9-537
Public Health
–Project FACE: Wisconsin surveillance of fatal occupational injuries (Hanrahan,Higgins,Haskins,Anderson):1-43
–Policy implications of increased heart disease mortality (MacDonald):2-88
–A rationale for universal screening for childhood lead poisoning (Schlenker):3-133
–The smoking continuum in Wisconsin, 1990 (Wetter, Remington,Pezzino):4-183
–Ground-level ozone in Wisconsin: potential health effects (Goldring,Morris):5-240
–Renal disease in Wisconsin: 1982-1990, increasing incidence of end stage (Sleath, Remington):6-303
–Sheepskin rugs linked to crib death (Chybowski):8-485
–Prostate cancer in Wisconsin: 1980-1990, increasing incidence of (Jochimsen, Remington, Phillips):9-537
–Breast cancer survival in Wisconsin (Lantz, Remington, Defo):10-597
–Cigarette smoking in Wisconsin, The increasing health and economic burden from (Chudy, Remington, Yoast):11-636
–Occupational healthcare in agriculture at the University of Wisconsin-Madison, Promoting (Chapman, Schuler, Wilkinson, Skjolaas):12-685
RBRVS: a primer, The:1-9
–RBRVS primer table of contents:1-10
–Resource directory:1-14
–History and future of the RBRVS, in brief:1-18
–Understanding the Medicare fee schedule disclosure:1-22
–Physician fees under the RBRVS:1-22
–Calculating fees for 1992:1-25
–The new CPT-4 codes:1-29
–Payments change for interpretation of EKGs:1-38
–Place of service code changes:1-40
–Extra care required with ICD-9 codes:1-42
Renal disease in Wisconsin:1982-1990, Increasing incidence

of end stage(Public health)(Sleath,Remington):6-303
Sheepskin rugs linked to crib death (Chybowski):8-485
Smoking continuum in Wisconsin, 1990, The (Public health)(Wetter,Remington,Pezzino):4-183
Soundings:1-7,2-66,3-123,5-210,6-273,7-338,8-472,9-522
-Sample cover letter for journal manuscript resubmissions (Reprinted from *Dialogue)*:1-7
-Allegory Harry in the year 2020 (Fogarty):2-66
-A moral response to the problems of the medical care system (Whaley):3-123
-Sickday (Temte):5-210
-A call for a national health care funding system:6-273
-Ad libitum (Rengel):7-338
-Hackers: a play in six scenes (Houghton):8-472
-Dear Betrayed Patient (Another doctor):9-522
Tube feeding in Wisconsin:medicine and law in conflict(Kane):5-235
WIPRO called an "evil system"(Fogarty):1-8
-WIPRO and the justification of existence (letters)(Mayersak):3-120
Worker's Compensation cases, Review process for reasonableness of fees and necessity of treatment disputes involving (Geis):10-591
Worker's Compensation System, Physicians and the (Vasudevan):10-595

State Medical Society–Organizational

Accreditation program for continuing medical education:7-405
Adams, Thomas L., Secretary's report:1-5,2-60,3-117,4-164,5-209,6-266,7-334,8-468,9-516,10-572,11-620,12-666
-150 years of caring for Wisconsin:1-5
-There's nothing like a cheap shot:2-60
-Every long journey starts with a single, small step:3-117
-For whom the bell tolls:4-164
-Only the inflexible died young:5-209
-The balanced budget bandwagon: let's look before we leap:6-266
-But she's my doctor! :7-334
-Only vertebrates can reform health care:8-468
-The view from here, it is time to stand up and make yourself heard:9-516
-Keeping the lid on Pandora's box :10-572
-The sun also rises:11-620
–Health care reform: the future is now:12-666
AIDS and HIV at SMS Workshop on Health, Teens seek answers about:12-689
AMA Physician's Recognition Awards:5-252,7-420,10-610
Amendments, to the SMS constitution and bylaws, Proposed:3-144
Annual Meeting:3-136,7-427,7-432,7-435,7-439,7-443,7-446,7-448
-*Then, now, and the future:* Highlights from the upcoming annual meeting:3-136
-Awards presented at the SMS annual meeting:7-448
-House actions on resolutions and reports:7-427
-House of delegates: 1992:7-432
-Executive vice president's speech, The search for our future (Adams):7-443
-Health care, the fallacy of (Correll):7-446
-Presidential address, Health care reform's future: the road less traveled (Hetsko):7-435
-Presidential elect address, The adventure continues (Listwan):7-439
Anti-smoking campaign in grade schools is expanded in honor of the SMS' 150th, Dodge county doctors accept the challenge:8-490
Beaumont, Discovery at Prairie du Chien: the story of Dr William:2-91
Board action reported, SMS returns to Racine:8-487
Board of Directors adopts new guidelines on HIV-infected health care workers, SMS:2-95
Cary, MD, Bushnell B., The first president of the State Medical Society of Wisconsin (Thayer,Wolfe):1-47
Charitable, Educational and Scientific Foundation
-CESF facts:7-453
-CESF guide to gifts, A:7-457
-CESF history:7-454
-Fort Crawford Medical Museum, The:7-455
-Foundation grant allocations:7-454
-September thru December 1991:2-103
-January and February 1992:4-198
-March thru May 1992:8-504
-June thru August 1992:9-557
–September thru October 1992:12-697
Charter law of the SMS:7-380
Commissions, committees and task forces, SMS, 1992-93:7-370
Constitution and bylaws, IMGs propose changes to section:3-152
-Proposed amendments to the SMS constitution and bylaws:3-144
-SMS constitution and bylaws:7-381
Dodge County doctors accept the challenge, Anti-smoking campaign in grade schools is expanded in honor of the SMS' 150th:8-490
County society news:1-50,2-101,3-153,4-188,5-254,6-319,7-418,10-606,11-657,12-698
–Ashland-Bayfield-Iron:12-698
-Brown:1-51,12-698
-Columbia-Marquette-Adams:1-51,10-606
-Dane:1-51,3-153
-Dodge:6-319
-Eau Claire-Dunn-Pepin:4-188
-Fond du Lac:5-254,6-319
–Grant:12-698
-Green:2-101
-Jefferson:10-606
-Kenosha:1-51,12-698

-La Crosse:2-54
-Manitowoc:1-51
-Marathon:1-51,2-101,2-54,6-319,10-606
-Milwaukee:6-319,7-418,10-606
-Oconto:12-698
-Oneida-Vilas:1-51,5-254,10-606
-Oshkosh:10-607
-Outagamie:2-101,6-319,11-657,12-698
-Ozaukee:5-254,12-698
-Pierce-St Croix:2-54
-Price-Taylor:11-657
-Racine:1-51,2-54,7-418,10-607,11-657
-Richland:1-51
-Rock:1-51,3-153,10-607
-Rusk:1-51,4-188,7-418,10-607
-Sheboygan:12-698
-Vernon:1-51,6-319,11-657,12-698
-Walworth:12-698
-Waukesha:1-51,5-254,10-607,12-698
-Winnebago:2-101,3-153,4-188,6-319,11-657,12-698
Domestic violence poster distribution begins, campaign gains exposure:8-492
Dominican Republic, A Wisconsin medical team travels to the (McCanna, Saine, Mullaney, Avery, Czomak, Helin):11-637
Editorials:2-63,3-118,6-269,9-520
-An enemy in the mirror (Lamont):2-63
-Professor, Professor (Sautter):3-118
-A favorable first impression (Sautter):6-269
-National Practitioner's Data Bank (Sautter):9-520
Expense reimbursement policy and procedure for physicians on SMS business:7-378
Financial report, SMS:7-379
Glimpse into our past, A (Sautter):2-94,4-191,5-250,6-317,7-423,9-551,10-603,11-654,12-684
Gundersen legacy, The:10-599
Health care a human face, Giving, A new program gives the public a peek at what it means to be a doctor (McCollum):12-693
Health care reform debates, SMS members delve into:3-155
Health care reform, SMS task force looks at:8-492
Health program, Statewide physician:7-402
Hmong, Providing health care for the (Waters, Rao, Petracchi):11-642
Index to articles:12-701
Mediation and peer review services:7-403
Medical assistance plan fails to improve access for OB services, SMS:8-488
Medicine, The march of (Tenney, Kahlor):11-653
Membership facts:7-406
Middleton, MD, 1890-1975, Vision, imagination, and leadership: William Shainline:3-147
Milwaukee County General Hospital, 1965-1980, From municipal hospital to medical center (Friedberg):9-547
Newcomb, MD, 1886-1956, Angel on snowshoes: Kate Pelham (Kahlor):4-187
Nominees for SMS offices:1992-1993:3-138
Obituaries:1-52,2-107,4-193,5-254,6-320,7-419,8-504,10-607,11-658,12-698
-Ansfield, David J., Milwaukee:2-107
-Babby, Louis, Milwaukee:10-607
-Bares, George C., West Bend:5-254
-Bear, Nathan E., Fayetteville, Ark:4-194
-Belson, Michael J., Green Bay:12-698
-Berman, Alvin L.(PhD), Madison:4-194
-Blodgett, Sr, Frederic M., Brookfield:5-254
-Blount, Walter P., Milwaukee:7-419
-Bohrod, Aaron, Madison:5-254
-Boyle, Joseph F., Virginia:10-607
-Boxer, Leo M., Milwaukee:2-107
-Braun, William E., Merrill:4-193
-Brodhead, William T., Madison:11-658
-Buscaglia, Anthony T., California:10-607
-Buskiewicz, Ted S., Greenfield:10-607
-Chase, Samuel L., Madison:7-419
-Cheli, Clement F., Columbus:12-698
-Cochrane, William, Tennessee:10-608
-Cree, Edna M., Middleton:10-608
-Dodds, Wylie, Brookfield:11-658
-Epstein, Ely, Milwaukee:11-658
-Foster, Mark Anthony, Blue Mounds:11-658
-Foster, Ruth C., Blue Mounds:11-658
-Frisch, Robert A., Milwaukee:10-608
-Fromm, Arno H., Madison:4-193
-Gabriel, Youssef H., Rothschild:2-107
-Garry, Mark W., Milwaukee:12-699
-Goetsch, Frederick H., Spooner:4-194
-Hansen, Arthur C., Wauwatosa:4-194
-Harned, Lewis B., Madison:7-419
-Hatchfeld, Douglas, Oshkosh:12-699
-Holbrook, Arthur Andrews, Mequon:10-608
-Johnson, Hugh A., Phelps:12-699
-Jorris, Edwin H., Sarasota, Fla:6-320
-Kashnig, David M., Milwaukee:10-608
-Kaufman, Bruce H., Whitefish Bay:7-419
-Kay, Eugene M., Santa Monica:10-608
-Kindwall, Josef A., Milwaukee:12-699
-Knights, John A., San Jose,Calif (Superior):4-194
-Kriwkowitsch, George M., Madison:8-504
-Larkin, Watson B., Marshfield:5-255
-Larson, Harry H., Ashland:7-420
-Lee, Chungki, Hartford:1-52
-Lerner, Neil A., Shorewood:7-420
-Madison, Frederick W., Milwaukee:5-255
-Malec, John P., Madison:12-699
-Marquis, William E., Waunakee:4-195
-Matt, Joseph R., Oconomowoc:4-193
-McKittrick, Norval W., Bayside:10-608
-Mellencamp, Franklin J., Milwaukee:2-107

-Mookerjee, Marcus K., Milwaukee:6-320
-Niles, Earl W., Elm Grove:5-256
-Niver, Edwin O., Eau Claire:4-193
–Norris, Arthur G., Wauwatosa:12-699
-Owen, Russell H., Milwaukee:4-195
-Pansch, Frank N., Madeira Beach, Fla:4-195
–Paulbeck, Theodore M., Elm Grove:12-699
-Pohle, Herbert W., Shorewood:1-52
–Prouty, Margaret "Jo", Madison:12-700
-Radl, Cyril J., Manitowoc:1-52
–Regala, Jr., Emilio B., Hartford:12-700
-Ruehlman, David B., Sunnyvale, CA:8-504
–Ryan, Donald J., Ephraim:12-700
-Sadoff, Harry B., Fox Point:4-194
-Schneider, Clarence J., Waupun:2-107
-Schmitz, John T., Milwaukee:4-194
-Schuh, Ruth R., Watertown:2-107
-Servis, Lionel T., Milwaukee:6-320
–Seward, Lynn J., Berlin:12-700
-Shearer, Charles E., Milton:4-194
-Smith, Donald A., Fond du Lac:4-195
-Spitzer, Sheryl Ann., Madison:10-608
-Steckler, Armin, Brookfield:8-504
–Storey, James David, Lee Township:12-700
–Taber, Alan, Berlin:12-700
-Vetter, Edward W., Fond du Lac:10-608
-Villavicencio, Celso A., Madison:10-608
-Vrabec, Andrew Paul, Beaver Dam:10-609
–Wadina, Gerald W., West Allis:12-700
-Waffle, Robert L., Fond du Lac:5-256
-Weld, Stephen L., Two Rivers:6-320
-Williams, Gail H., Marshfield:8-504
-Wohlwend, Edward Bruce, Beaver Dam:5-256
-Wright, Eugene N.,Oshkosh:1-52
-Zeiss, Edward J., Appleton:10-609
-Ziegler, Clement Thomas, Whitefish Bay:11-658
Officers and directors, SMS, 1992-93:7-359
Officers and directors by district, SMS:7-408
Officers of the SMS specialty and special sections:7-395
Officers of Wisconsin's county medical societies:7-389
Officers of Wisconsin specialty societies:7-398
150th Celebration Wrap-up
–A presidential perspective, Is anyone listening?(Listwan):12-673
–Why group practice? A young physician's answer (Turney):12-675
–The nature of university practice (Kabler):12-678
–Large group or small: a family medicine perspective (Gruling):12-679
–An interview with the dean, Medical schools are adapting to the future (Hamilton):12-681
–A glimpse into our past (Sautter):12-684
Physicians briefs:2-96,3-150,4-193,5-251,6-318,7-416,8-501,9-553,10-604,11-655,12-696
Physician-Citizen of the Year nomination letter:9-556
Physicians Insurance Company of Wisconsin: state of the corporation:7-424
Physicians' support group, SMS:7-404
Pollution, Madison physician joins global fight against (Hamilton):12-695
Potter's Field of Milwaukee County, The, Field of Blood, field of the forgotten:8-493
President's page:1-3,2-59,3-115,4-163,5-205,6-263.7-331,8-465,9-513,10-569,11-617,12-665
-150 years of SMS; enter Medicare RBRVS (Hetsko):1-3
-The challenge to medical schools (Hetsko):2-59
-The status of the health care financing crisis in Wisconsin (Hetsko):3-115
-Health care financing reform in Wisconsin: Prescription for the future:4-163
-Stay the course(Listwan):5-205
-Wisconsin's deadly secret–domestic violence (Listwan):6-263
-Filling station philosophy (Listwan):7-331
-The bell tolls for us (Listwan):8-465
-Let's kick a little butt (Listwan):9-513
-Politics and war (Listwan):10-569
-Safe at home(?) (Listwan):11-617
–Happy holidays (Listwan):12-665
Publications and reprints available:7-414
Resource directory, SMS:7-411
SMS secretary-general manager travels to the shores of Lake Michigan:2-102
SMS Secretaries, Saga of:7-421
Senn, MD, 1844-1908, The great master of abdominal surgery:(Hamilton):5-245
Treavitt, MD, 1858-1928, A remarkable woman: (Volkert):6-315
Ukraine, Mobile clinic brings care to,After the meltdown (Hamilton):9-541
Voice of the SMS: 6-268
-Medicine and the Milwaukee media (Temte):6-268
WIPRO Board, Three SMS members elected to:11-652
WISPAC and Physicians for Better Government:7-418
Wisconsin Medical Journal
-Index to advertisers:1-53,2-112,3-161,4-202,5-260,6-326,7-462,8-510,9-565,10-614,11-622,12-710
-Classified section:1-49,2-109,3-158,4-199,5-257,6-323,7-459,8-507,9-561,10-611,11-659,12-707
-WMJ writing Contest:1-12
-Photo contest corrections:5-251
-WMJ physician photo contest:4-168
-William Hocking, MD, wins '92 WMJ photo contest:4-196
-WMJ Instructions to authors:6-321

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Department of Corrections (DOC); Division of Program Services; Bureau of Correctional health Services; Madison. Start between $31,008 and $37,472 per year (50% of the annual salary for the position) depending on qualifications. A supplemental amount not to exceed $3100 annually will be granted for supervisory responsibilities. A twelve-month probationary period is required. **Job Duties:** Provide medical input into all facets of the correctional health service program for inmates and juveniles incarcerated in the state correctional institutions. This includes the planning, implementation and evaluation of all levels of services as defined per statutes standards and policies. Supervise medical staff assuring a level of performance and care consistent with community standards of practice and as mandated by State Statutes which govern health services in Wisconsin. TRAVEL TO VARIOUS CORRECTIONAL INSTITUTIONS THROUGHOUT THE STATE IS REQUIRED. **Special Requirement:** A license to practice medicine in the State of Wisconsin is required. **How to Apply:** Apply with the Application for State Employment Form (DER-MRS-38), cover letter and resume to Beatrice Chatman; DOC; Bureau of Personnel and Human Resources; 149 E. Wilson Street; P.O. Box 7925; Madison, WI 53707-7925. Application materials will be accepted until the needs of the service are met. Application materials will be reviewed and only those applicants who meet the special requirement indicated above will be invited to participate further in the selection process. Direct questions about the position to Sharon Zunker, Director, Bureau of Correctional Health Services at (608) 267-1730.

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Family Practice Physician Board Certified - Board eligible to join 25 physician multispecialty group in Winona, Minnesota with existing four physician Family Practice Department. Total draw of 40,000 population. Competitive salary offered. Interested physicians please contact: J. B. Knuesel, Administrator, Winona Clinic, Ltd., 420 East Sarnia, Winona, MN 55987. 10-12/92

Oshkosh, Wisconsin. Medical groups are recruiting in Internal Medicine, Pulmonology, Rheumatology, Emergency Medicine, OB/GYN, Child Neurology, Child Psychiatry, Ophthalmology, and Urgent Care. Mercy Medical Center has an active medical staff of 110 physicians in all medical specialties. Oshkosh is an attractive community of 55,000 people, located on the shores of Lake Winnebago and in the heart of Wisconsin's beautiful Fox River Valley (metro area of 400,000 people). University of 12,000 students. Competitive financial packages. Contact Christopher Kashnig, Mercy Medical Center, 631 Hazel Street, Oshkosh, WI 54902. Call 414-236-2430 or 800-242-5650, extension 2430. Fax: 414-231-5677. 10-12/92

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Family Practice opportunities in Wisconsin, Illinois, New York, Michigan and Arizona. Urban, suburban, rural, solo, single specialty and multispecialty groups. All offer attractive compensation packages, with competitive salaries, benefits, income guarantees. For more detailed information about each of these practice opportunities, contact Carol Radke at 800-969-7715 or fax CV to 414-226-4131. All inquiries will be kept strictly confidential. 10-12/92

Staff psychiatrist. Medium-size smoke-free environment medical center offers primary and extended care to a large area of west central Wisconsin. Full range of psychiatric services include admissions (acute), geriatric, long-term care, out-patient, PTSD, and alcohol. Salary range to $119,500, depending on qualifications and board certification. Excellent benefits package includes malpractice protection, 30 days paid vacation, and annuity plan. Relocation expenses. 173-acre facility includes limited on-station housing and nine hole golf course. City of 7500 in a predominantly rural area that offers affordable real estate, good schools. conveniently located on I-90/94 midway between Milwaukee and Minneapolis. Call or write: Eugene J. Traynor, MD, Chief, Psychiatry Services (116A), VA Medical Center, 500 East Veterans St, Tomah, WI 54660; ph 1-800-252-7188. EO/AAE. 5-12/92

Internist. Two young BC Internists are seeking a third BC/BE Internist for well established, rapidly growing practice located in pleasant central Wisconsin University town of 30,000. Ideal practice opportunity with equal balance of consultative and primary care; well equiped 120 bed hospital, 12 bed ICU. Comprehensive benefit package includes first year salary guarantee, full malpractice insurance and partnership buy-in after one year. Send CV to: Stevens Point Internal Medicine, SC, 3504 E. Maria Dr., Stevens Point, WI 54481. (715) 341-8044. 10/92-3/93

Physicians Exchange

Continued

Family practice - Internal medicine to join seven BC family practice physicians and one BC general surgeon in beautiful northern Wisconsin. Clinic facility is attached to hospital and new nursing home. Resort area. If your family life and life style are important to you, this is the opportunity. Contact Stephen Carlson, MD, or Jeanne Chamberlain, Adm, Northwest Medical Center, 707 Ash Street, Spooner, WI 54801; ph 715-635-2151. 7-12/92

Family practice physician needed by progressive and growing group practice in west central Wisconsin. City of 60,000. Ninety miles from Minneapolis/St Paul. Primarily prepaid practice with large component FFS. Highly competitive salary with excellent fringe benefits. Practice high quality care in good recreational area. Send CV to Stuart Lancer, MD, MBA, PO Box 3217, Eau Claire, WI 54702-3217; ph 715-836-8552. 10-12/92

Wisconsin. Family practitioner needed by a growing practice of a four physician group in a friendly rural community in northeast Wisconsin near Green Bay. This is an excellent opportunity to join an established organization. Highly competitive salary with benefits. Please contact: Artwich Clinic, Oconto Falls, WI 54154. p7-12/92

Wisconsin. 120 physician multi-specialty clinic in the Fox River Valley of northeastern Wisconsin desires two BC/BE pediatricians to join department of 15 BC/BE pediatricians. Excellent compensation and benefit package, leading to shareholder status after two years. The community offers a superb recreational, cultural, and family environment in which to practice. For information please call or write: Howard Kidd, MD, La Salle Clinic, 411 Lincoln St, Neenah, WI 54956; ph 414-727-4276. 3tfn/91

Family practitioner-internal medicine-OB/GYN to join progressive 13-physician group practice. Rural college town 30 miles from St. Paul, MN. New clinic and new hospital. Contact Robert B. Johnson, MD, River Falls, WI 54022 (715) 425-6701. c9tfn/91

Milwaukee suburb. Established and growing multi-specialty full-service clinic. Attractive benefits, salary, and early partnership opportunity. Positions available in internal medicine, family practice, and pediatrics. Please send CV to Administrator, Park Crest Medical Clinic, SC, 2665 South Moorland Rd, New Berlin, WI 53151. 3tfn/91

Madison, Wisconsin. Positions available: family practice and locum tenens in family practice (full time). Excellent salary, benefits, lifestyle. Contact Professional Staff Coordinator, Group Health Cooperative, 1 South Park St, Madison WI 53715; ph 608-251-4156. GHC is an equal opportunity/affirmative action employer. 6-7/92;tfn/92

The Wausau Medical Center is seeking board certified/eligible individuals in the following specialties: dermatology, family medicine, gastroenterology, hematology/oncology, obstetrics/gynecology, orthopedics, otolaryngology, rheumatology, walk-in (urgent care). Large multi-specialty group located in central Wisconsin. Competitive salary (incentive after first year). Comprehensive benefit package including malpractice insurance, flexible benefits plan and profit-sharing. Modern facility located directly across the street from 250-bed acute care facility. The area is ideal for outdoor enthusiasts (including large downhill ski area) with outstanding cultural activities year-round as well. Write or call collect D. K. Aughenbaugh, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, WI 54401; ph 715-847-3254. c1tfn/91

Internist to join two internists in active practice in scenic Upper Michigan. Medical school affiliation. Contact North Shore Internal Medicine, 2420 First Ave South, Escanaba, MI 49829; ph 906-786-1563. p11tfn/91

For Sale

For sale: Recently closed clinic selling barely used Bennett X-ray equipment including developer, silver recovery and leaded room. Also left over tables, desks, CBC, chemistry machines, etc. Call 414-344-7200. Ask for Yvette. 12/92

THIS LISTING is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, clinics, specialty societies, and medical schools are particularly invited to utilize this listing service. There is a nominal charge for listing of Continuing Medical Education courses at the following rates: 55 cents per word, with a minimum charge of $25.00 per listing. *All listings must be prepaid.*

BOXED LISTINGS: $30.00 per column inch. Listings of other scientific meetings will be included at the discretion of the editors.

COPY DEADLINE for listings is 1st of the month preceding the month of publication: *eg,* copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, WI 53701; or phone 608-257-6781; or toll-free 1-800-362-9080.

OTHER MEETINGS in the United States are published in the first issue of each month of the *Journal of the American Medical Association.*

WISCONSIN—OHIO
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Medical Meetings-Continuing Medical Education

January 14-15, 1993. Nephrology Update in Clinical Practice, January 14-15, 1993, Rushmore Plaza Holiday Inn, Rapid City, SD, Fourth Annual Conference Sponsored by: Department of Internal Medicine, USD School of Medicine and Rapid City Regional Hospital. Contact Pat Sivesind, Registrar, Department of Internal Medicine, USD School of Medicine, PO Box 5046, Sioux Falls, SD 57117-5046, (605) 339-6790. 12/92

February 11-12, 1993 - 17th Annual Winter Pediatric Conference. Indianhead Mountain Resort, Wakefield, Michigan. Contact: Marshfield Clinic, Office of Medical Education, 1000 North Oak Avenue, Marshfield, WI 54449. 1-800-782-8581, ext. 5207.

AMA

June 13-17, 1993: Annual AMA House of Delegates, Chicago.
December 5-8, 1993: Interim House of Delegates, New Orleans.
June 12-16, 1994: Annual AMA House of Delegates, Chicago.
December 4-7, 1994: Interim House of Delegates, Honolulu.

State Medical Society of Wisconsin

Dates and locations of
ANNUAL MEETINGS
1993-1994

The 1993 meeting will be in La Crosse. All other meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel, unless otherwise indicated.

1993 - April 14-17: La Crosse Convention Center, Radisson
1994 - April 13-16: Milwaukee

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, WI 53701. Local Telephone: 257-6781; toll-free in Wisconsin: 1-800-362-9080.

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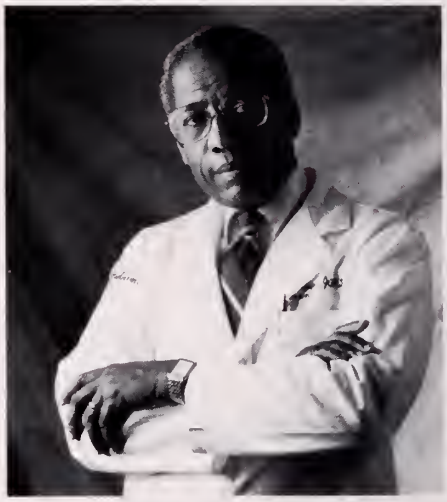

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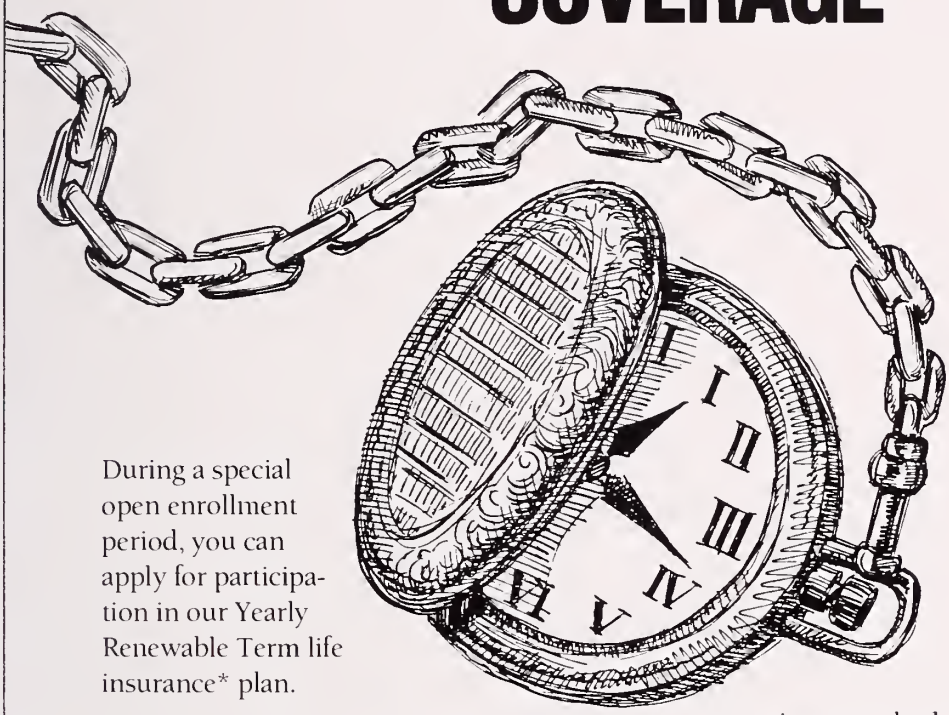

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